

General Practitioners at the Deep End

The experience and views of general practitioners working in the most severely deprived areas of Scotland

Prof. Graham Watt MD FRCGP FMedSci



Royal College of
General Practitioners

General Practitioners at the Deep End

The experience and views of general practitioners working in the most severely deprived areas of Scotland

Graham Watt

Professor of General Practice, University of Glasgow

On behalf of the Deep End Steering Group

Georgina Brown, GP, Springburn Health Centre

John Budd, GP, Edinburgh Homeless Practice

Peter Cawston, GP, Drumchapel Health Centre

Margaret Craig, GP, Allander Surgery, Possil

Robert Jamieson, GP, Bridgeton Heath Centre

Susan Langridge, GP, Possilpark Health Centre

Andrew Lyon, International Futures Forum

Stewart Mercer, Professor of Primary Care Research, University of Glasgow

Catriona Morton, GP, Craigmillar Health Centre

Anne Mullin, GP, Govan Health Centre

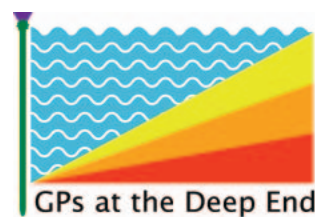
Jim O'Neil, GP, Lightburn Medical Centre

Euan Paterson, GP, Govan Health Centre

Petra Sambale, GP, Keppoch Medical Centre

Graham Watt, Professor of General Practice, University of Glasgow

Andrea Williamson, GP, Glasgow Homeless Health Services



Address for correspondence

Prof. Graham C.M. Watt, Norie Miller Professor of General Practice,
General Practice and Primary Care, University of Glasgow, 1 Horselethill Road,
Glasgow G12 9LX | Tel: 0141 330 8345
email: graham.watt@glasgow.ac.uk

Published by

The Royal College of General Practitioners | April 2012



Royal College of
General Practitioners

Charter

The Royal College of General Practitioners was founded in 1952, with this object:

To encourage, foster and maintain the highest possible standards in general medical practice and for that purpose to take or join with others in taking steps consistent with the charitable nature of that object which may assist towards the same.

Among its responsibilities under its Royal Charter the College is entitled to:

Encourage the publication by general medical practitioners of research into medical or scientific subjects with a view to the improvement of general medical practice in any field and to undertake or assist others in undertaking such research.

Diffuse information on all matters affecting general medical practice and establish, print, publish, issue and circulate such papers, journals, magazines, books, periodicals and publications, and hold such meetings, conferences, seminars and instructional courses as may assist the object of the College.

Occasional Papers

The Occasional Paper series was established in 1976 to offer authors the opportunity to publish manuscripts too long for publication as articles and too short for books. They are assessed for academic acceptability by the Editor, College Publications, and other professionals with special interests. Readers should note that they express the views of the authors, and not the College, unless otherwise stated.

Occasional Papers are included in *Index Medicus*.

Copyright

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise without the prior permission of the Royal College of General Practitioners.

© Royal College of General Practitioners | 2012

ISBN: 978-0-85084-338-5

Contents

Summary | iv
Foreword | v
Commentaries | vi

1 Introduction | 1
2 The Deep End logo | 2
3 The first meeting | 3
4 The Keppoch Medical Practice | 5
5 The nature of patient encounters | 7
6 Anticipatory care in very deprived areas | 9
7 Vulnerable children and families | 11
8 Alcohol problems in adults under 40 | 13
9 Social Prescribing | 15
10 Learning journeys | 17
11 Time to make a difference | 19
12 The tortoise and the hare | 21
13 Inventing the wheel in general practice | 23
14 A social institution based on mutuality and trust | 25
15 Reflections on the Deep End | 27

References | 29
Annexes | 30

Summary

This Occasional Paper captures the experience and views of general practitioners (GPs) at the Deep End, comprising GPs serving the 100 most deprived practice populations in Scotland. The paper builds on a series of articles that were published in the *British Journal of General Practice* in 2011.

Deep End practices are at the front line of the NHS in addressing the health and health-care problems of severely deprived communities. Although they have substantial knowledge, experience and authority, they have largely been neglected in discussions, reports and policies about inequalities in health.

By increasing the volume, quality and consistency of care provided for individual patients, and harnessing the intrinsic strengths of general practice – including coverage, continuity, co-ordination, flexibility, long-term relationships and trust – general practices in very deprived areas can improve population health and narrow inequalities.

There are two important barriers. The first is the inverse care law, best understood as the result of NHS policies that restrict access to care based on need, and which is manifest every day as the shortage of time within consultations to address patients' needs. Second, there are dysfunctional links with the wide range of other professions and services, whose contributions and partnership are needed to deliver needs-based care.

There is no single or short-term solution. A sustained and integrated package of measures is needed, combining at least six key elements.

- 1 Deep End practices need *more time and capacity* to address unmet need.
- 2 Best use needs to be made of *serial encounters* over long periods.
- 3 Practices need to be better connected with other professions and services *as hubs of local health systems*.
- 4 There need to be better *connections between practices* across the front line, following the example of the Deep End Project.
- 5 The front line needs to be better *informed and supported by NHS organisations*.
- 6 *Leadership* needs to be developed and supported at practice and area level for all of these activities.

The NHS should be at its best where it is needed most. Otherwise, the delivery of effective health care will widen rather than narrow health inequalities. Deep End practices can lead the way.

Foreword

Occasional Papers are seminal papers that make a statement, and this paper is no exception. The foundation for this treatise on the need to improve health care for those living at 'the Deep End' (in severe deprivation), by decreasing morbidity and increasing longevity, is the original tenet of the NHS in 1948: to provide access to health care for all, regardless of ability to pay. However, this paper pivots on the difficult challenges that still remain as a result of 'the inverse care law'. This was first reported in 1971 by Julian Tudor Hart, a London-born and -trained GP who went on to practise for three decades in Glyncoed, West Glamorgan, Wales. His observation was that those patients who have the greatest health need, e.g. in inner cities, appear to receive the poorest-quality health care and so 'good medical care' tends to be inversely related to the needs of the population. This led to his seminal publication in the *Lancet* (Hart, JT. The Inverse Care Law *Lancet* 1971; **297**: 405–12).

Although this Occasional Paper originates from Scotland, it has ramifications for inner-city populations living in severe deprivation anywhere in the UK and beyond. Prof. Graham Watt has coordinated and collated this important paper on behalf of the Deep End Steering Group and provides a definition that captures the essence of this project:

In severely deprived areas, this results in a major mismatch of need and resources, with insufficient time to get to the bottom of patients' problems – hence the swimming-pool analogy in which GPs at the Deep End are treading water.

He goes on to say that 'the NHS should be seen at its best where it is needed most' and that 'the goal for health-care must be to find ways of increasing the volume, quality and consistency of care in deprived areas'.

The Deep End Project is based on the 100 most deprived general practice populations in Scotland and began with a series of 15 meetings to capture the views and experience of Deep End GPs. The challenge is complex and goes well beyond the artificial and narrow range of evidence-based targets such as those incentivised by the Quality and Outcomes Framework (QOF). This paper argues that change is also needed via 'the unconditional, committed and continuing care provided for all patients, especially those with multiple morbidity and social problems', requiring not only

adequate consultation time but also measures to address the 'dysfunctional relationships between general practice and other local professions and services, leading to fragmentation of patient care'.

The paper argues the need for public health practice to be based in primary care where patient contact substantially occurs. The paper highlights two public health issues of growing concern and which affect Deep End GPs on a daily basis: the 'unfolding epidemic' of alcohol-related illness and the ramifications of 'worklessness'. The paper describes well the very nature of the general practice consultation to which doctors should be able to respond: 'Many patients present with concerns that arise from their social situation, and the management of long-term medical conditions is often affected by personal circumstances.'

The paper concludes that the answer is not 'rocket science' but simply to bridge the gap between what practices serving very deprived areas are able to do and what they could do if supported on the basis of need.

The great challenge to all general practice is to value the subjective aspects of patient care that cannot be measured but which depend on the provision of adequate consultation time. A pilot study in the paper reports how 'extra time was associated not only with increased reported enablement by patients with complex problems, but also reduced practitioner stress and increased reported enablement by other patients receiving usual consultations'.

I would recommend this paper to be read by all those working in general practice or managing and commissioning primary care services. I have merely scratched the surface of a paper that has vital messages for primary care in the UK and globally, and should form the basis of discussion for primary care teams, Associates-in-Training and politicians as they take the NHS towards 100 years in 2048.

Prof. Rodger Charlton MD FRCGP

Honorary Editor of RCGP Publications

Commentaries

Richard Horton

Inequality is a matter of life or death. How badly we have failed to defeat it.

A common approach to health policy-making is to begin with an empty page and to fill it with evidence. Thick reports emerge from eminent professors and personages. They assemble evidence, draw general conclusions, and make abstract recommendations. Their findings are fantastic enterprises of scientific synthesis. Their work usually commands universal gratitude and glittering prestige.

In one recent influential report on inequalities of health, the policy recommendations are ambitiously big and broad. Give every child the best start in life. Enable all children, young people, and adults to maximise their capabilities and have control over their lives. Create fair employment and good work for all. Ensure healthy standards of living for all. Create and develop healthy and sustainable places and communities. Strengthen the role and impact of ill-health prevention. These goals are staggeringly laudable. Few could quarrel with their intent. As practical tools for addressing the social determinants of health, they are close to useless. They provide little help to those whose responsibility it is to reduce inequalities in health – except as moral slogans to appease society's guilt.

None of these criticisms can be laid at the door of the Deep End project. This unique initiative is based on the idea that GPs are professionals engaging with the direct consequences of health inequalities. It is they who are doing a great deal to ameliorate the determinants of ill health. It is they who, if supported to do so, could achieve a great deal more.

General practice is a vital dimension of public health, and vice versa. Yet these two communities tend to inhabit mutually exclusive worlds. Sometimes, they are even devotedly hostile to one another. Deep End unites these two important and interdependent fields at a critical moment. The increase in multiple morbidities among older populations is widening inequalities still further. Those who have first and subsequently continuous contact with patients enduring complex co-morbidities therefore have a special part to play in reducing inequalities. Enter the GP.

For GPs to deliver what they know they can deliver will

require extraordinary assistance: expanded time, networks of relationships, and leadership. Based on the experience Deep End has provided, Graham Watt is justifiably optimistic. Deep End explores the biological and social mechanisms of Julian Tudor Hart's powerfully articulated and widely influential inverse care law.^{1,2} The description of the inverse care law was not a Newtonian moment. The 'law' can be broken. And it can be reversed if general practices are supported to address their unmet needs. If GPs received help on the front line through a realignment of NHS resources, if the political commitment so often promised was truly delivered, much could be achieved for those living amid pervasive deprivation.

Deep End also challenges the epidemiological fundamentalism that has so bedevilled medicine in recent years, including the social determinants of health. As one Deep End GP said about the initiative:

I thought [about] this micro-political level of the everyday stories we hear – people say that is just anecdote, it isn't really evidence, but that's nonsense. This is evidence. What these people tell us is evidence of whether the system is working or not. Whether society is functioning or not functioning.³

Epidemiology is important, but sometimes even epidemiology needs to be put in its place. Deep End does so.

A final note. Although the Deep End initiative derives its strength from the lived experiences of communities in Scotland, the findings it has generated have a reach and importance well beyond Scottish borders. The kinds of profound engagement between human beings, which Deep End fosters, challenge medicine's conventional notions of the doctor and patient. Too often, patients are seen as objects of clinical service or scientific study. Instead, Deep End is about the patient and doctor together participating in an alliance to defeat inequality. The GP enters into the situation of the patient and, in solidarity, both attack inequality side-by-side.

General practice embodies two principles of health that are the foundations of social justice – universalism and equity. As Graham Watt argues, the NHS is an extraordinary 'social institution based on mutuality and trust'. Thanks to

the institution that is the NHS, together with the core values of general practice, the Deep End project offers a vision for the future of medicine and society that is transformative not only in its aspiration, but also in its reality.

Richard Horton FRCP FMedSci
Editor-in-Chief
The Lancet

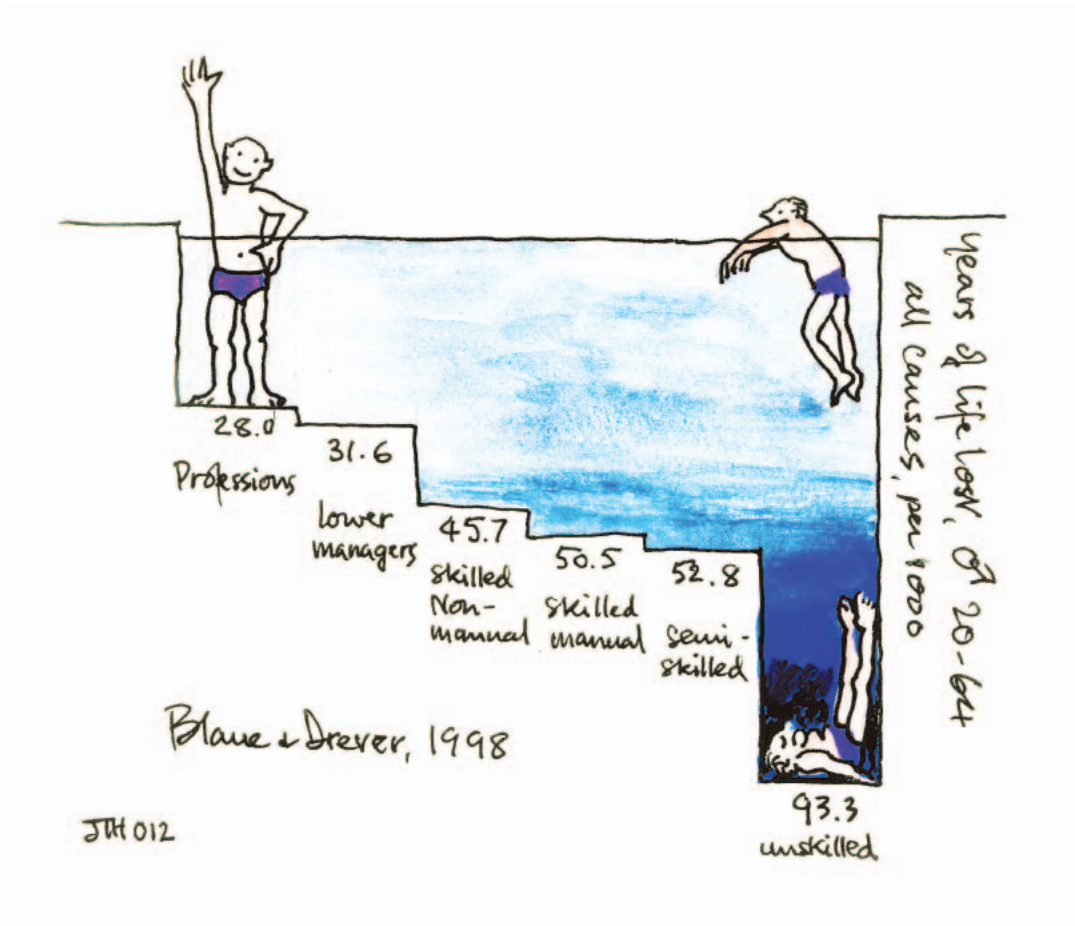
1 Tudor Hart J. The inverse care law *Lancet* 1971; **297**: 405–12.
2 Watt G. The inverse care law today *Lancet* 2002; **360**: 252–4.
3 Mackintosh K. Deep end *Holyrood*, 19 September 2011: 32–5, www.holyrood.com.

Julian Tudor Hart

The NHS transformed care from a commodity to a human right, and, by planning distribution of its workforce, it provided staff numbers roughly proportionate to catchment populations. But these numbers remained inversely proportionate to workload. Graham Watt devised the Deep End metaphor.¹ For people with problems, and for staff helping them, what

matters is not a level surface free from icebergs, but how deep it is, and how heavy are the cares they carry. The pool in Figure 1 deepens proportionately to years of life lost through deaths from all causes at ages 20–64, grouped by occupational class.² In 1991–93, male unskilled manual workers lost about three times as many years of potential life from deaths

Figure 1 □ The drowning pool, 1991



under 65, as professionals. Between 1970–72 and 1991–93, years of life lost for social class 1 fell from 15.3 per 1000 to 6.1 per 1000, whereas for social class 5 there was almost no change (22.8 to 20.4). More recent data confirm these trends. With these additional premature deaths come even more sickness, fear and heartbreak, the immense additional primary care workload wherever it is most needed and hardest to give.

Civilisation is a product of struggle, not of refined tastes. It took experience of two world wars, interrupted by two decades of playboys and playgirls alongside mass unemployment, to produce Bevan's NHS, with its assertion of priority for the needs of people over the rights of property. To win equality of workload, and thus equality of consultation time, will demand similar levels of mass understanding.

Local and area leadership is the most important but also the most problematic of the six elements identified by the Deep End Group as essential to success. What about national leadership, for the UK as a whole? Could the NHS ever have been born, without a Bevan to fight for its life? We certainly have none now.

Scattered throughout the UK, Deep End primary care teams already exist, if only in the minds of professionals still trying to preserve their communities, rather than look for profitable customers. They are organised and materially supported only in Scotland, but, even there, they still have no assured future. In Scotland, Wales and Northern Ireland, devolved governments are committed to return to the principles of the NHS as a unified public service, but they have done almost nothing to inform and mobilise public opinion even within those regions, let alone the UK. Bevan relied on people's capacity to learn rapidly through their own experience, trusting both doctors and patients to defend the NHS through the bad times he knew lay ahead. No such trust can exist among leaders of mainstream UK political parties, because, to defend the existing social order, all believe they must take decisions painful to most of their voters. Their power depends on deception sufficient for them to appear marginally less untrustworthy than their opponents.

For the immediate future, this necessary step has no political leaders. Even in Scotland, Wales and Northern Ireland, devolved governments have yet to put enough resources behind projects like Deep End to inform and mobilise public opinion through their own local experience, and thus develop area leaders. So everything depends on leadership at practice level, demanding media attention, gaining broad public support, and insisting on material

resourcing from their governments, in return for which they can guarantee immensely greater efficiency of care given to and received by people who know each other. We command far more public affection and respect than politicians. We have listed populations with names, addresses and votes. We already have power. We must learn how to use it.

Julian Tudor Hart FRCP FRCGP

- 1 Watt GCM. Not only scientists, but also responsible citizens (Milroy lecture) *Journal of the Royal College of Physicians of London* 1998; **32**: 460–5.
- 2 Blane D, Drever F. Inequality among men in standardised years of potential life lost, 1970–93 *British Medical Journal* 1998; **317**: 255.

1 | Introduction

This Occasional Paper summarises the first two years of the Deep End Project, based on the 100 most deprived general practice populations in Scotland.

A series of 15 meetings sought to capture the views and experience of Deep End GPs, as a resource for addressing the health and social problems of people in very deprived areas, improving their health and narrowing health inequalities (Annex A). The key messages of these meetings were distilled in a series of 12 articles in the *British Journal of General Practice* (BJGP) (Annex B). This Occasional Paper collates the BJGP articles as a document of record, summarising what has been achieved, and the way forward.

The project has been supported by the Royal College of General Practitioners (Scotland), the Scottish Government

Health Directorate and the Glasgow Centre for Population Health. It also works closely with the Lothian Health Board Deprivation Interest Group and the Greater Glasgow and Clyde Deprivation Group.

Special thanks are due to Andrew Lyon (International Futures Forum), Ken Lawton and John Gillies (successive chairs of the Council of RCGP Scotland), Carol Tannahill (Director of the Glasgow Centre for Population Health), Linda De Caestecker (Director of Public Health, Greater Glasgow and Clyde Health Board), Roger Jones and Alec Logan (BJGP), and Frank Strang (Scottish Government Health Directorate) for their support of the Deep End Project.

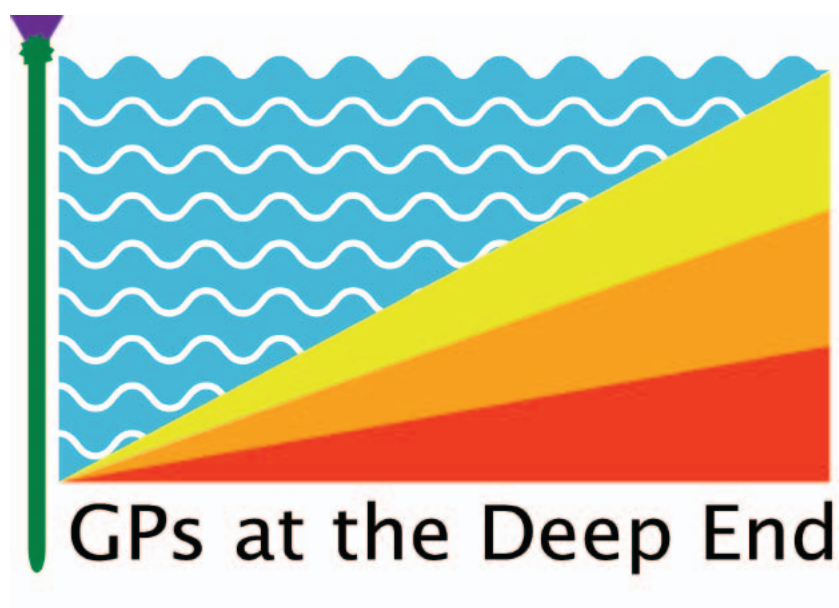
Graham Watt MD FRCGP FMedSci

Professor of General Practice

University of Glasgow

January 2012

2 | The Deep End logo



The Deep End logo, which is explained in section 3, includes:

- ▶ the deep end of a swimming pool
- ▶ gradients, including the steep slope of need and the flat distribution of manpower
- ▶ a flag to represent practitioners at the Deep End
- ▶ a thistle
- ▶ a spurtle (a traditional Scottish stirring instrument)
- ▶ a sunrise.

3 | The first meeting

In September 2009, RCGP Scotland held an unprecedented meeting involving GPs from the 100 most deprived general practices in Scotland. It was the first time in the history of the NHS that this group had been convened or consulted.

The College had set up a working group to produce a report on what general practices in Scotland could do to address inequalities in health.¹ The group made three early decisions. First, it would not replicate the many previous and largely ineffective reports on inequalities in health, reviewing the partial literature and drawing partial conclusions. Second, it would not issue GPs with a 'toolkit', the approach of technocrats, which assumes that GPs only need to be told what to do. Third, it would listen to what GPs from the front line had to say.

The College established a budget that would allow locum fees to be paid. The Scottish Government Health Directorate agreed to match the College's funding. On the day, GPs from 63 of the 100 most deprived general practices attended, along with four GPs from homeless practices in Glasgow and Edinburgh, four GPs from rural practices including small areas of deprivation, and two civil servant observers. The day was spent talking, in groups and open forums, to capture the experience and views of GPs from the Deep End.

The Deep End

Practices had been ranked according to the proportion of the patients on their lists living in the 15% most deprived datazones in Scotland, based on postcodes characterised by the Scottish Index of Multiple Deprivation² – the target population for Scottish Government policies to address inequalities in health. Deep End practices have from 50–90% of their patients in this category, and collectively serve 33% of people living in the most deprived 15% of datazones. The other 67% is served by 700 other practices in Scotland. Thus, the Deep End project has focused on blanket deprivation, rather than pocket deprivation, on the grounds that this is where a new start most needs to be made.

The Deep End epithet arose from the observation that, while the prevalence of health problems rises 2.5–3.0-fold across tenths of the socio-economic spectrum, the dis-

tribution of GPs is almost flat.¹ Since 1948, the NHS has supplied GPs in the same way that bread, butter and eggs were rationed in World War 2 – everybody gets the same. In severely deprived areas this results in a major mismatch of need and resource, with insufficient time to get to the bottom of patients' problems – hence the swimming pool analogy in which GPs at the Deep End are treading water. The analogy does not imply that GPs at the Shallow End are not busy, or that they do not have demanding patients, but their patients generally live much longer and most present less complex burdens of need.

The challenge

No one at the meeting was under any illusion about the many social determinants of poor health, and the need for measures outside general practice to protect and promote the current and future health of local populations. However, health care increasingly makes a difference to population health (some 30–40% of recent improvements in life expectancy), and, if this is delivered inequitably, health care can widen inequality.³ The challenge for health care is to find ways of increasing the volume, quality and consistency of care in deprived areas.

The practices

Eighty-five of the original top 100 practices were based in Glasgow City, with five in Inverclyde, five in Edinburgh, two in Dundee, two in Ayrshire and one in Renfrewshire. Forty-six of the practices are based in two Community Health Partnerships (CHPs), in Glasgow East and North, where they comprise 84% of all practices. The others are a minority of practices in the CHPs in which they are based.

The average list size is 4316, with 20 single-handed practices and 60 with three GP partners or less. There is no

difference in the number of points achieved in the Quality and Outcomes Framework (QOF) between Deep End practices and other practices in Scotland.⁴ About a half of practices take part in undergraduate teaching, a quarter in postgraduate training and two-thirds in research (via the Scottish Primary Care Research Network) and primary care development (via the Scottish Primary Care Collaborative).

The meeting

The meeting was largely based on the sharing of experience and views. Many of the participants knew each other well from other activities. However, the focus on practices serving populations with concentrated deprivation and the absence of colleagues representing other types of practice were novel. In the final session, several commented on the almost immediate and strong group identity of practitioners from the 100 most deprived practices and the positive, cathartic nature of the meeting.

It was clear that Scotland does not have many of the problems of general practice in deprived inner-city areas, which have provided the context for much primary care development in England. Despite the heavy burden of health needs and demands, and their impact on both patients and staff, general practice serving areas of concentrated deprivation in Scotland is characterised by high quality (as measured by the QOF), high morale (as demonstrated by involvement in additional professional activities) and high commitment to improving services for patients (as evident by the discussions at the meeting). However, much more could be done.

The meeting strongly affirmed, indeed took for granted, the strengths of the general practice model, based on contact, coverage, continuity, coordination, flexibility, relationships, trust and leadership.⁵ There was frustration, however, from lack of resources, lack of support, lack of identity and marginalisation within current NHS arrangements. A strong theme was the problematic and dysfunctional nature of many external relationships, including those with non-practice-employed staff, local authority services and community health partnerships. Many practitioners regretted the devaluing of consultations, considered to be the heart of general practice, by the financial incentives of the new GMS contract.

The topics selected by participants for discussion were a mixture of issues particular to deprived areas (e.g. mental health and addiction, patient empowerment, resource allocation and support for practitioners) and issues of relevance to all general practices (e.g. multi-professional working,

relationships with secondary care, infrastructure and premises, and relationships with CHPs).

A GP from Edinburgh commented,

I was in groups made up entirely of non-Lothian GPs. What was striking was not only that we got on well, but on how much convergence there was in terms of the problems we face. I was in the primary/secondary care group and virtually everything said by Glasgow GPs, I could have said first about Edinburgh – to a surprising level of detail. That problems seem to be so very generic and uniform across the board hopefully means that there might be generic and uniform answers too.

What next?

The immediate challenge was to build on the engagement, enthusiasm, ideas and precedent generated by this first meeting. Could the extraordinary nature of the meeting be made ordinary, so that the top 100 general practices become a more effective force for improving primary care?

4 | The Keppoch Medical Practice

The Keppoch Medical Practice serves the most deprived patient population in Scotland, and is based at Possilpark Health Centre in Glasgow.

According to those who have worked elsewhere, the only difference in our Deep End practice compared with other practices is that there are 'very few easy cases'. For a GP in problem-solving mode it can be galling to find so few solutions – the chest problem cannot be cured immediately because giving up smoking, in a life fraught with anxiety and debt, can only be achieved in the long term. To allow this to happen, the practice has needed more resources than are required in a 'normal' practice. Otherwise we would have been repeating the mistakes of the past in depriving the deprived of any hope of change. A major resource need concerns communication.

The only real way to ensure that doctor and patient are on the same wavelength is for face-to-face meetings to pick up the non-verbal signals. Unread leaflets are regularly found discarded on the ramp from the surgery. Of course there is no point in using doctor time when all that is needed is to communicate that there are others with the necessary skills in the community. The main difficulty, however, lies in gaining the patients' confidence that such a transfer of care to a stranger is not a threat. That needs longer consultations to talk through the issues. GPs also need to know of nearby community resources. Our strategy for making the best use of these often transitory resources is to make time for doctors and nurses to meet the project workers.

Only by having weekly practice meetings with all the GPs, health visitors, district and practice nurses, with the monthly addition of a social worker, an addiction worker, and a school nurse, can everyone appreciate the people and families at risk of failing to receive medical and social care, the signs to look for, and the resources available to help. We are all too aware of the need to prevent the tragedies of Peter Connelly, Brandon Muir and Victoria Climbié happening in our practice.

Sometimes the only way to monitor a child is when a granny attends for her own illness. If you do not notice the child in the surgery or waiting room you may miss a rare opportunity to observe and share with others in the

practice team. Likewise, if the woman with the chest problem also suffers from obesity, diabetes and ischaemic heart disease at the age of 39, a 10-minute GP consultation often becomes 20 minutes to start to address some of her problems. Such opportunistic activity plays havoc with the appointment system, which has needed to have a substantial degree of flexibility built in.

The next step in dealing with the woman with her list of problems is to constantly remind her to engage with practice nurses and hospitals. For example, receptionists, staff on the prescription desk and managers, as well as GPs and practice nurses, need to have a coordinated recall system for titration and monitoring of medication.

GP support is important for practice nurses and GP trainees. The ischaemic heart disease review becomes complex if uncontrolled epilepsy and lack of contraception are picked up. Our GP trainees are often overwhelmed by the agenda of our patients, including social, addiction and bereavement issues in addition to their medical problems, and by their lack of background knowledge concerning individual patients.

In a pilot study, which provided increased time for consulting with complex patients in our practice, extra time was associated not only with increased reported enablement by patients with complex problems, but also with reduced practitioner stress and increased reported enablement by other patients receiving usual consultations.⁶ This promising initiative deserves wider and longer-term application.

At present, we are a PMS/Section 17c practice (one that has a locally negotiated agreement, enabling, for example, flexible provision of services in accordance with specific local circumstances), which enables us to deliver the standard of service we regard as necessary. However, in times of austerity, we increasingly experience funding cuts, impeding the quality of service we are able to provide.

General practice in an area of high deprivation requires continuity of care, supported teamwork, networking with community resources and an intimate knowledge of family

backgrounds. The Deep End Project has helped us to reflect on our work, to learn from models of good care provided by other teams and to strengthen our identity as GPs working in a deprived area. Peer support and developing solutions from grassroots experience are motivating factors.

We welcome the Scottish Government's aim of reducing inequalities in health via concerted action across government.⁷ We believe a comprehensive approach, including education, housing, employment opportunities, health, and a concentration on early years and parenting, is paramount in achieving better outcomes for our patients. In our opinion, GPs have a unique role in the communities where they work.

We think GPs have the skill to answer the challenge of providing holistic patient care for a deprived population and of tying together a fragmented care system. Eighty-eight per cent of our patients belong to the most deprived 15% of Scotland's population. For a practice with 'so few easy cases', adequate resources are needed not only to deliver high-quality coordinated care, but also to prevent demoralisation and burnout.

Robert Mandeville

Petra Sambale

5 | The nature of patient encounters

Consultations in severely deprived areas are characterised by multiple morbidity, especially psychological co-morbidity, lower patient enablement and practitioner stress.

Early in the Deep End Project, 15 GPs met for a workshop on patient encounters in very deprived areas, drawing on experience, evidence⁸ and policy, and focusing on what can be achieved and how.

Consultations with patients are the largest and most important part of the work of GPs. Consultations always address the problems presented by patients on the day (reactive care), but can also address potential future problems (anticipatory care). A key aspect of the consultation is the relationship between the patient and the doctor, who often know each other from previous consultations. This prior experience is an important aspect of the professional intuition required to know how and when to extend the aims of a consultation. Maintaining the relationship and ending on a positive note are important outcomes of each consultation.

Research has shown that patients in deprived areas are less likely than patients in affluent areas to wish to have an active role in decisions concerning their care.⁹ Patients may also be less interested and ready to address changes in health behaviour. Addressing such issues within consultations is time consuming and is often not immediately effective. Explanations may take longer due to problems in health literacy. Practitioners describe 'chipping away' at these issues, rather than achieving large and sudden changes in behaviour.

Whether a consultation includes more than reactive care depends on many factors, including appropriateness, having time available, and patient and practitioner expectations. Practitioner stress can affect both practitioner and patient behaviour within a consultation, influencing what the patient presents and how the practitioner responds. NHS policies tend to underestimate the constraints and difficulties in moving beyond reactive patterns of patient and practitioner behaviour.

The incentives of the QOF do not reward practitioners for extending consultations beyond a narrow range of targets, and the QOF agenda, highlighted via computer alerts, can be felt as an intrusion in the consultation. Current NHS ini-

tiatives concerning patient self-help and self-management appear to have poor penetration in deprived areas and were not recognised by practitioners at the meeting.

Consultations are more likely to be successful if carried out in a systematic way, establishing the patient's agenda at the outset, picking up clues ('psycho-social red flags') and ending with clear agreement as to what has been decided. Surgeries can be made more efficient by good practice organisation, involving clear communication and the involvement of other members of the team including receptionists and practice nurses.

A frequent and important aspect of many consultations is referral to other professionals and services. Referral is most likely to be taken up when it is quick and to a familiar local setting. When a referral is made outside the practice, some patients would benefit from additional help and reminders to increase the probability of the referral being taken up.

Practices provide a hub for referral to a huge range of other professions and services. Many of these pathways are dysfunctional, with poor communication and feedback. Multi-professional working across organisational boundaries works best via established relationships with named individuals, with regular, reliable contact and opportunities for professional exchange.

Practitioners are keen to make use of the full range of possible services and sources of help for patients, but frequently lack accurate and up-to-date information about what is available locally. Patients also need ready access to health information and resources available within the local community. It is not clear whose job it is to provide such information and to keep it up to date.

Evidence is needed on the best ways of providing access to different types of consultation (simple or complex), using additional time within consultations, linking with other professional colleagues and services, making good use of community information, and providing support for both patients and professionals.

There are too few opportunities for practitioners working in severely deprived areas to share experience and views

concerning the conduct of consultations and the organisation of practices. Additional education and training is required not only for young practitioners preparing to work in deprived areas, but also for established practitioners, building on their substantial knowledge, experience and ideas to improve services for patients.

The most important barrier to addressing the inverse care law remains the shortage of time within consultations. Unless this root cause of the inverse care law is addressed, the resulting inequalities in health will persist.¹ It is encouraging that Members of Parliament serving deprived areas in Scotland and in England are beginning to bang this drum.

6 | Anticipatory care in very deprived areas

The cardinal feature of Julian Tudor Hart's practice was an unconditional approach to all of the problems presented by his patients, providing continuity and coordination, and using epidemiology to measure what he had and hadn't done.

A paradox of public health practice within the NHS is that, while doctors with public health in their job titles tend to have little contact with the public, GPs who have substantial contact with the public tend not to think about public health. Both groups tend to underestimate the public health function of general practice.

When Willie Sutton, the famous US bank robber, was asked why he robbed banks, he replied, 'Because that is where the money is.' When asked why general practice is important for public health, the answer is, 'Because that is where the contact is.'

Serial contacts with individual patients in general practice provide continuity, flexibility, shared knowledge, long-term relationships and trust – all key ingredients of effective long-term care. Cumulative contact with practice patients provides a large measure of population coverage. Whereas screening and research are considered to have done well when they reach 70% of the population, primary care regularly has contact with over 90%. No other part of the NHS has this degree or type of coverage.

The contact is of a particular kind, however, contrasting with the cold-calling approach of screening programmes and is almost always instigated by patients, requiring practitioners to address the presenting problem before moving on, if appropriate, to other issues.

The pioneer of anticipatory care in general practice was Julian Tudor Hart.¹⁰ Although his example has been used by several Ministers of Health to justify programmes of cardiovascular risk screening via health checks, Tudor Hart never screened his practice population and never used health checks. Instead, he used routine contacts to build up coverage of his population, using special measures only for patients who had been missed out using this approach.

The other major misperception of his work is that the approach was not restricted to applying the evidence-based medicine of the day (anticipating the QOF), mainly addressing the risks of high blood pressure, smoking and

diabetes. The cardinal feature of his practice was an unconditional approach to all of the problems presented by his patients, providing continuity and coordination, and using epidemiology to measure what he had and hadn't done. The epidemiology was new, but the interventions were mainstream.

As part of the Deep End Project, 20 GPs from Glasgow, Edinburgh and Inverclyde met to review their experience of Keep Well, the Scottish national anticipatory care programme, including cardiovascular health checks and referral to health improvement programmes such as smoking cessation, exercise, obesity and other health behaviours.¹¹

The group concluded that focusing on the 45–64 year age group was starting too late in deprived areas, where people aged 55–64 are already 'elderly' in terms of reduced life expectancy and the prevalence of multiple morbidity. Deep End practitioners know many patients in their 30s with multiple risks and problems who would benefit from anticipatory care.

While screening programmes can process large numbers of people very quickly, they lack sustainability, are generally poor at contacting the last 30% of the population and impose an external agenda, which may be neither sufficient nor timely, especially for patients with multiple problems.

The health check approach 'of encouraging patients to attend for a health check and then to support them to follow an agreed behaviour change and or treatment regime' is simplistic and flawed, in relation to those patients with complex needs. The experience of Deep End GPs is that, while health checks have worked for some patients, there are many patients, especially those with alcohol, literacy, psychological and social problems, for whom health checks work less well, and whose involvement in health improvement activities requires a different approach. The problems of alcohol are particularly acute, and a greater cause of premature death in severely deprived areas than cardiovascular disease.

In general, increased caseloads for cardiovascular risk prevention in general practice, as generated by screening programmes, are only feasible with additional resources, a team approach and effective links to external professions and services. Such external resources are much more plentiful than they were in Tudor Hart's day, but are often not effectively integrated with the opportunities and needs for health advice and support, occurring regularly but fleetingly in day-to-day practice.

The best arrangements for supporting practices serving areas of blanket deprivation are unlikely to be the same as those required by practices serving areas of pocket deprivation. As Willie Sutton might have said, resources need to be concentrated 'where the deprivation is'.

Like compound interest, the public health benefits of mainstream general practice accrue not immediately but towards the end of a period of sustained investment.¹² The challenge is not only to ascertain risks, but also to follow this up, working with patients (in Tudor Hart's phrase 'initially face to face, eventually side by side'), flexibly but consistently, as needs determine, over the long term. By the sum of such relationships, the NHS can improve health and narrow inequalities.

7 | Vulnerable children and families

Working with vulnerable families is an everyday aspect of general practice in severely deprived areas. Through many types of contact, practice teams acquire substantial knowledge about the most vulnerable families in their registered populations. Their frustration is not being able to help more effectively at an early stage.

Key issues are how this knowledge is acquired, how it should be used and how to link with other professions and services. Several recent NHS developments have undermined the knowledge that practice teams acquire. For example, the withdrawal of child surveillance in deprived areas is considered a mistake, given the high yield of health and social problems. Burnout and loss of staff due to excessive caseloads removes from practices the knowledge, experience and relationships that colleagues have developed over many years.

Pregnancy is an important opportunity to demonstrate how professions and services can work together. No one argues that midwives are best placed to lead on matters directly concerned with the pregnancies and deliveries of most women but the main causes of maternal mortality and morbidity during pregnancy are no longer obstetric in nature. A review of the issues identified at booking in one severely deprived general practice population¹³ shows the wide range of associated problems including addiction, mental health, ethnicity and language, in addition to medical problems. For such women, care during pregnancy should not be an isolated episode but part of a continuing, coordinated process. General practice can add the flexibility, unconditionality, accessibility (often 'the last stop', when other services do not respond) and continuity that families need.

At a meeting on working with vulnerable children and families, attended by 20 Deep End GPs and 60 colleagues from other professions and services, two GPs gave powerful presentations on their ability to deliver coordinated, personal continuity of care for pregnant women with complex problems.¹³ Unusually, one presentation was able to describe the long-term benefits of a practice-attached midwife, while the other described the advantages of working with a practice-attached social worker. Whether working with patients or with professional colleagues, the active ingredient is a long-term relationship based on communication, mutuality and trust.

All agreed that current resource provision is inadequate to stem the tide of vulnerable families that recent economic and social policies in the UK have helped to produce. There was also concern that by concentrating scarce professional resources, such as health visitors, on the highest-risk families, less preventive work will be done to reduce the number of families progressing to high-risk status. The policy may be counter-productive before long.

When time is short and caseloads are large, thresholds for intervention are bound to rise. Practice teams are often aware of vulnerable children and families before serious problems develop, but lack the resources to intervene. Investments are needed in home support, free nursery places and other ways of supporting families.

To address the inverse care law, the GP contract and/or enhanced service agreements should explicitly support practices in working with vulnerable families in ways that are commensurate with the numbers of vulnerable families within practices, and not just the numbers of cases on child protection registers. Practices should identify their lead professional for vulnerable families, coordinating activities within the practice and considering the ways in which they could work more effectively with other practices and with other professions and services, including social workers and school nurses.

Effective joint working depends on colleagues knowing each other's names, being well informed about each other's roles, knowing how they may be contacted locally and understanding the constraints under which they work. Professionals and services should be accountable not only for their own contribution but also how this connects with the contributions of others. The 'connectedness' of care should be a major policy, management and practitioner objective. The hallmarks of a caring system are not only the quality of encounters between practitioners and families, but also the extent to which the system measures itself in providing needs-based support to all who need it, matches rhetoric

about joint working by measures to support and review joint working, provides continuity of care, and assesses itself against a range of outcomes, including the views of parents and children. A caring system should also care for its staff, ensuring reasonable caseloads, sharing the burden and finding practical ways of encouraging and rewarding commitment and continuity.

The Deep End meeting provided an example of how practitioners and managers from different services can learn from each other, share experiences, correct misperceptions, and discuss how services can be improved. The extraordinary nature of the meeting needs to be made ordinary, as part of a learning organisation, dedicated to supporting professionals and services working with vulnerable children and families.

8 | Alcohol problems in adults under 40

Through caring for individual patients with alcohol problems, GPs and their colleagues in primary care are daily witnesses to an unfolding epidemic.

GPs working in the most deprived areas of Scotland have special experience of the problems of alcohol, not through choice but because of the huge, recent and increasing importance of excessive alcohol consumption as a cause of premature death, physical illness and social harm affecting young patients.

The issue of excessive alcohol use cropped up in several Deep End meetings. At a meeting to discuss anticipatory care, based on health checks for cardiovascular and other risks, it was noted that alcohol is a bigger cause of premature deaths in young adults in very deprived areas than cardiovascular disease. At another meeting practitioners observed the increasing need for the palliative care in the community for patients with alcoholic liver disease and their families.

At a meeting funded by the Scottish Government Health Department, Deep End practitioners met with a range of professional colleagues, including members of community addiction teams, to share experience and views of alcohol problems in adults under 40.¹⁴ The general view was that the NHS allocates fewer resources to address alcohol problems than might be expected, given their impact on individuals, families, the NHS and the economy. In Glasgow, dedicated Community Addiction Teams cope with less than half of the estimated number of people with severe drinking problems, leaving others to seek care where they can find it, including general practice.

For people needing help there are many possible entry points to the system. There needs to be clarity about the paths they may then follow. Pathways are important for planning, integrating and evaluating services, but people with alcohol problems often lead chaotic lives, so there is also a need for continuity and flexibility based on ongoing relationships with professionals whom they know and trust.

The role of GPs is to assess risk, provide brief interventions, minimise harm, manage physical problems and co-morbidity, and act as a signpost to other NHS, local authority and voluntary services. Effective links between services are the key to integrated care. General practices and community

addiction services should actively review their links in terms of professional relationships, communications and record of joint working. Shared information concerning the progress of patients through systems is essential, and can be helped by improvements in IT, although there are issues concerning confidentiality (whether people are content to have their personal information shared) and professional engagement (GPs vary in how they respond to information communicated from third parties).

The meeting raised many unanswered questions including the effectiveness of brief interventions in young adults, and arrangements for detoxification, joint working, sharing information and practice-attached alcohol workers. Practitioners were only too aware, however, of the limited effect of service improvements on their own.

Through their work in caring for individual patients with alcohol problems GPs and their colleagues in primary care are daily witnesses to an unfolding epidemic. This collective experience and knowledge needs expression, to inform public debate and influence health policy. In the week prior to the debate in the Scottish Parliament on minimal alcohol pricing, 40 Deep End practitioners united for the first time to make their views known via a letter to the *Herald* newspaper:

Scotland's statistics are shocking, but 'statistics are people with the tears wiped off'. The current debate about alcohol pricing can lose sight of the misery and devastation that affects our patients and their families, especially the lasting effects on children. Drunken disorder is only the most obvious problem. Every one of us knows of tragic cases of young adults whose lives, and whose family lives, have been ruined by alcohol. Women are particularly vulnerable. No one should die young and yellow from chronic alcohol poisoning.

This is not an issue that can be left to personal responsibility or the massed efforts of health practitioners trying hard to stem the tide. Any measure, such as minimal alcohol pricing, which makes it more difficult for people to consume regular excessive amounts of alcohol should

be seized, as a public health measure of the highest importance. Cross party support is the least we should expect from our politicians, especially those representing the most deprived constituencies, in confronting this very real and lethal epidemic.

Politicians in Scotland and England have still to engage seriously with the issue of minimal alcohol pricing. If this is not the solution, what do they suggest? GPs at the Deep End will continue to advocate for political action, following Sigerist's dictum.¹⁵

The social causes of illness are just as important as the physical ones. The ... practitioners of a distressed area are the natural advocates of the people. They well know the factors that paralyse all their efforts. They are not only scientists but also responsible citizens, and if they did not raise their voices, who else should?

9 | Social Prescribing

I didn't become a GP to spend my life prescribing pills.

Respondent, Deep End Report 9

Social and medical problems are often not differentiated by patients who look to GP practices for help. Many patients present with concerns that arise from their social situation, and the management of long-term medical conditions is often affected by personal circumstances. Doctors need to be able to respond to this wider picture. Indeed, the extent to which doctors are able and willing to take into account their wider daily lives and concerns is seen as a key element of good-quality medical care by patients who live in socially deprived areas.¹⁶

Many GPs develop some knowledge about resources outside of the health service that can assist patients, for example, with financial problems, domestic violence or housing issues. Some GP practices also work with outside groups to promote or plan local resources. This practice of signposting patients to non-health service resources has been labelled Social Prescribing.

Ten GPs working among some of the most deprived patient populations in Scotland took part in a small study to examine the extent to which Social Prescribing forms part of their clinical work.¹⁷

Two major themes emerged from this reflection. The first is GPs' awareness of the disabling impact of policies. The second is their aspiration to emphasise the strengths of patients themselves to tackle their own problems.

GPs are aware of the problems that many of their patients face: low pay, alienating work conditions, low expectations, poor educational achievement, ready access to drugs of addiction, including alcohol and tobacco, worklessness, poor nutrition, poor physical and mental health. Many of these factors are inter-generational and affect children from the earliest age.

They point out that rationing on medical grounds of resources, including benefits and housing, emphasises disability. Personal anxieties and social problems are repackaged as medical problems such as mood disorder or chronic pain. For many patients this appears to be the only channel

available by which to struggle for self-betterment.

GPs are concerned that doctors' reports provided in response to requests to prove medical need set them up as gatekeepers for social resources. Signposting patients in crisis to welfare advocates may add to this dependency if they need to emphasise that their client is a sick person in order to achieve a basic standard of living. This can create conflict between seeking to improve the patient's long-term self-efficacy, and responding to the immediate welfare needs and expectations of the patient.

Despite these concerns, GPs recognise Social Prescribing as a valuable part of their practice. They believe that community resources are important in supporting the health of their patients. They also acknowledge the role of advocacy in helping patients to make better use of health services. Moreover, they express concern about the impact on their patients' welfare caused by budget cuts to voluntary groups.

GPs emphasise the constraints on space, time and personnel, and the need for clear boundaries as to what primary care has to offer. Many social and personal problems cannot be dealt with effectively by the GP and require community resources. Practice-attached health visitors provide an important link between the practice and the community in relation to child welfare.

GPs do not see the role of the practice team as simply that of providing information about a list of services, but rather as using their experience and empathic relationships to support patients to make use of the most appropriate resources at the right time. Community resources are most valued by the GPs when they are seen to help people develop the positive ability to improve or 'take ownership' of their own health. These might include writing or creative arts groups, carer support, volunteering and educational opportunities, as well as more traditional resources such as addiction services or exercise schemes.

In summary, the GPs who took part in the Social Prescribing Project think it is important to help patients take control of

their own health and wellbeing. They see this as a core primary care role, centred on their personal relationships with individual patients. They value other organisations that can further this goal, and regularly point patients in their direction.

The GPs believe that the following key recommendations would support more effective Social Prescribing in primary care:

- ▶ a well-maintained, locally relevant and user-friendly internet directory of community resources for use by practitioners
- ▶ more medical and nursing time in consultations to respond to very challenging needs by giving clear explanation and guidance
- ▶ clear guidance for patients and organisations approaching GP practices for reports or advocacy support
- ▶ extension of the Primary Care Team to include a practice-attached social worker, employability adviser and mental health worker
- ▶ increased funding to voluntary and local agencies in deprived communities and protection from budgetary cuts
- ▶ benefits reform that reflects the realities of life in Scotland's poorest communities, and which guarantees a basic standard of living to all rather than seeking to distinguish between deserving and undeserving poor on medical grounds.

Peter Cawston

10 | Learning journeys

If we do not change direction, we shall arrive where we are heading.

Chinese proverb

An occupational hazard of GPs is that they can be so busy attending to the problems of their patients and practices that they have no time to consider where they are heading. As an alternative to their daily work, Andrew Lyon of the International Futures Forum led two groups of GPs from Deep End practices on learning journeys to a variety of surprise destinations.

The workplaces visited included public, private and voluntary organisations: *KEY Community Supports*, an organisation that re-settles people with learning disabilities from large institutions to small community settings; a social entrepreneur, leading the *Family Business Association*, whose members have to combine business disciplines with family relationships; *GalGael*, an organisation that rehabilitates people with addiction and other problems via craft-based activities, principally building and sailing traditional clinker-built boats; *Glasgow Life*, the charity responsible for running the city's public cultural facilities and sports centres; *Bridging the Gap*, an organisation that works to bridge any gap which divides people living in the Gorbals; and *Percepta*, which provides telephone-based support for the customers of major car companies, with very low staff turnover and high customer satisfaction, focusing on the customer not the car, and enabling staff to have high levels of individual autonomy and discretion.

The groups of GPs spent 90 minutes in each location. Each setting had its own distinct feel on arrival and GPs, who had perhaps been expecting to do a lot of talking, found themselves listening intently to passionate hosts who had found ways to liberate and enthuse people in their work, combining daily activities with long-term values and aspirations. Work was no longer a drudge or a dead end but a means of individual and collective expression.

The journeys they were on, their directions of travel and modes of operation were as important as their hoped-for destinations. Steady growth is more important than fast growth for its own sake. Being busy is not an intrinsic virtue.

Spending time doing the wrong things is not effective.

A common feature that emerged was the tension between local action and the need to work via large organisations to address social problems of poverty, deprivation and social exclusion. There was a feeling that many of these large organisations had lost their way. Their impersonal, bureaucratic nature can lack a human dimension, adding to the alienation that many people experience in everyday life. The antidote that these colleagues had found was cumulative, shared knowledge and engagement, based on communication, relationships and trust.

At *KEY Community Supports*, for example, some of our hosts described the situation that faced them as parents of children with learning disabilities, when they were told 'there are places for children like these, just hand them over and you can get on with life'. The parents refused to accept that this was so. Thirty years later the institutions on which that system was based have been almost entirely replaced and the resources spread throughout communities. Based on a system of new relationships, people with learning disabilities (not their parents) sit on the board of *KEY Community Supports* and have a say in how the system is run. An enticing question loomed large: '*What other centralised NHS institutions are ripe for dismantling, redistribution and reinvention?*'

In *Bridging the Gap* at the Gorbals, our hosts described simple ways in which they changed the context for relationships between groups with opposing views, for example asylum seekers and the indigenous population. They created opportunities to meet socially and eat food from different cultures together. Using theatre and imaginative exercises they made circumstances where schoolchildren could understand what it might be like to flee your country. By changing the context, it is possible to change behaviour and break down the myths based on stereotypes. These can no longer hold when people know each other better.

The success of the innovative work seen on the visits was difficult to account for. Not everything that matters can be

measured and yet there must be accountability. A key question for many of our hosts was how to balance the licence required for innovation with the need to be accountable to supporters, funders and others outside the process.

The workplaces visited highlighted the fact that a large amount of good work is taking place in communities, but GPs, who may be aware of it in general terms, tend not to know what is happening and how they might help patients to benefit from it. With their longstanding local presence, knowledge, experience and connections, GPs could be an important part of such work, perhaps even a powerful force for change.

The learning journeys lit a pilot light. As one of our hosts told the GPs:

The world does not have to be as it is and it is never too late to change.

Andrew Lyon
Graham Watt

11 | Time to make a difference

I sit on a man's back, choking him and making him carry me, and yet assure myself and others that I am very sorry for him and wish to ease his lot by all possible means – except by getting off his back.

Leo Tolstoy, What Then Must We Do?

After 15 meetings and reports, the Deep End Project has had some success, establishing an identity for the scattered front line of practitioners serving Scotland's 100 most deprived communities, and capturing their previously unheard experience and views. It is a sobering fact, however, that the project has yet to make a material difference to the circumstances under which Deep End practitioners work. The remaining sections focus on what needs to be done.

Men and women in the most deprived tenth of the Scottish population have life expectancies 13 and nine years shorter, respectively, than men and women in the most affluent decile. They spend twice as many years in poor health before they die (10.3 versus 5.5 years for men; 14.4 versus 6.0 years for women).¹⁸ Yet the numbers of GPs serving such areas is the same.

There is no single or short-term solution. A sustained and integrated package of measures is needed, combining at least six separate elements. First, Deep End practices need more time and capacity to address unmet need. Second, best use needs to be made of serial encounters over long periods. Third, practices need to be better connected with other professions and services, as hubs of local health systems. Fourth, there needs to be better connections between practices across the front line, following the example of the Deep End Project. Fifth, the front line needs to be better informed and supported by NHS organisations. Sixth, leadership needs to be developed and supported at practice and at area level for all of these activities.

Additional time for Deep End practices is not sufficient, but it is essential. Very few of the very many reports and recommendations on health inequalities make any reference to the issue of time. If mentioned, the inverse care law is invoked as an Act of God, rather than a man-made policy that restricts access to care based on need. Experts on health inequalities have a collective visual field defect

concerning this issue. The RCGP Scotland report *Time to Care* is an important exception.¹

Of course, the most important policies for improving population health and narrowing health inequalities, concerning education, employment and the social environment, do not require one-to-one contact with the general population. But in so far as health policies require contact with the public, general practice is the main delivery system providing coverage, continuity, flexibility, sustainability and trust.

General practice makes a difference partly via the mass delivery of evidence-based medicine, as per the QOF, but also via the unconditional, committed and continuing care provided for all patients, especially those with multiple morbidity and social problems. If such care is provided inequitably, greater improvements in health in better resourced areas lead to widening health inequality. Current arrangements are not a satisfactory option. They lead in the wrong direction.

The continued existence of the inverse care law is explained, not by the provision of good care in affluent areas and bad care in deprived areas, but by the difference between what practices in deprived areas are able to achieve and what they could achieve if properly supported. This difference is apparent on a daily basis to Deep End practitioners, but has largely escaped detection by epidemiologists and statisticians, trying to understand general practice and unmet need from afar.

The principal mechanisms of the inverse care law are, first, inadequate time within consultations to address the full burden of patients' problems and, second, dysfunctional relationships between general practice and other local professions and services, leading to fragmentation of patient care.

Well-coordinated care is needed most by patients with multiple health and social problems, including the 15%

of patients who account for 50% of NHS activity. While a range of initial criteria may determine the need for integrated care (e.g. CVD risk, multiple morbidity, age, vulnerable families, etc.), the key contribution of general practice (as opposed to specific care programmes) is personal, flexible and continuing care for whatever combination of problems a patient may have.

The contribution of GPs to public health is via the sum of care provided for all patients. By addressing unmet need and improving the health of their patients, Deep End practitioners could do much more to prevent, reduce and delay the effects of poor health.

Intellectual opposition to social injustice is only the beginning of understanding.¹⁹ Reports and policies on inequalities in health need to address the inverse care law. More than 60 years on, the NHS could still show the world what universal coverage and needs-based services can achieve.

12 | The tortoise and the hare

Serial encounters in general practice are a fact, and individual patients attend all of them.

Everyone is familiar with Aesop's fable of the tortoise and the hare. Although the hare was faster over short distances, it was the plodding tortoise that won the race.

The recent history of policies and initiatives to address inequalities in health is littered with hare-brained schemes, exchanging long-term effect for short-term display. Many of these schemes are conceived in mad March, when there is end-of-year money to spend. Like genetically programmed crops, they disappear when the year is out.

Deep End GPs describe the life cycle of many community initiatives that, by the time they get established and become useful, are already starting to wind down. In maintaining a list of local community resources, the continuing challenge is to keep up to date.

Health check programmes are also in vogue and can process large numbers of people through the initial stages of risk assessment, but, when most of the resource goes into the beginning of the process, it is not surprising that so many programmes fizzle out.

A frequent notion of initiatives to address health inequalities is the 'transformative encounter', in which patient behaviour is changed by a single professional intervention. But such examples, however celebrated, are notable for their rarity, and unlike the reality of working with the large numbers of patients with multiple morbidity and complicated social problems.

Patients with long-term problems have few consultations in which diagnoses are made, but dozens and sometimes hundreds, in which the business of the consultation is living better with risks and conditions, and avoiding or delaying their complications. Yet the focus of most medical education, evidence, guidelines and NHS policies to address inequalities is on the start of this journey.

In the film *Brief Encounter*, Trevor Howard plays a GP who has a series of short, intense, emotional encounters with Celia Johnson's character in Carnforth railway station. As young people watching this film today are prone to say, 'Not a great deal happened.' The same is often true of brief encounters in primary care.

Serial encounters in general practice are a fact, and indi-

vidual patients attend all of them. The encounters may or may not feature continuity, in terms of practitioner contact or information sharing. They may or may not involve cumulative learning, co-production (with the patient taking an increasingly active role) or the building of social capital, by which patients acquire increasing knowledge, contacts, experience and confidence. But in the absence of adequate time to get to the bottom of problems, sustained effort and effective links with other professions and services, few of these things are likely to happen. Instead of serial progress, there are cycles of repetitive, non-productive behaviour.

Such trajectories are seldom simple. They stop and start, with reverses, delays, diversions and the intrusion of events. There is no 'logic plan'. But within this Brownian motion there can be constant purpose and steady progress – the tortoise rather than the hare.

In his book *A New Kind of Doctor*, Julian Tudor Hart described 25 years of care of a big, muscular man, who had been invalidated out of the steel industry following an accident at work.²⁰

For the staff at our health centre it was a steady unglamorous slog through a total of 310 consultations. For me it was about 41 hours of work with the patient, initially face to face, gradually shifting to side by side. Professionally, the most satisfying and exciting things have been the events that have not happened: no strokes, no coronary heart attacks, no complications of diabetes, no kidney failure with dialysis or transplant. This is the real stuff of primary medical care.

In a spat with Tudor Hart, Prof. David Sackett, a pioneer of clinical epidemiology and evidence-based medicine, remarked that it was the first time he had been likened to a snail. Ironically, it was by snail-like progress that Tudor Hart improved the health of his practice population.¹²

The future challenge is not to recreate this pioneering example of anticipatory care, but to deliver its essential elements via local health systems with general practice at the hub.¹⁰ Key ingredients are flexibility, constancy and an always open door. Perseverance is more important than

pace. Nor is perseverance one long journey; it is many short journeys, one after another.

The disappearance of personal doctors is greatly exaggerated. At a recent meeting of three Deep End GPs with a journalist, there were over 60 years of local experience in the room, and an enormous amount of knowledge, commitment and compassion on display (Annex E). Such knowledge is no longer the preserve of GPs, and is frequently acquired by other members of the health team. Exchanging such knowledge is an important team function.

All that GPs can do to reduce inequalities in health is via the sum of care they provide for all their patients. To realise this contribution, the NHS needs not only to address the inverse care law, increasing the volume and quality of care where needs are greatest, but also to understand, value and support serial encounters in primary care.

13 | Inventing the wheel in general practice

In very deprived areas, the spokes connecting general practice hubs and other local services have to be short.

As multiple morbidity becomes more common, budgets tighten and inequalities widen; the fragmentation of health care is increasingly prevalent, expensive and unacceptable.

Fragmentation of care occurs when encounters with patients address only some of a patient's problems, when practitioners are not informed by previous encounters and do not inform the encounters that follow, when the left hand of the service does not know what the right hand is doing, and when care is delivered on a partial basis, for example by responding primarily to demands rather than to needs.

Fragmentation of health systems often occurs in conurbations, when some services are delivered on the basis of GP lists and other services are organised at an area level. Federations of general practices can fragment care within areas when only some practices are involved.

A consistent conclusion of Deep End meetings has been that general practices offer a ready solution to the problems of fragmentation, as they are the natural and sustainable hubs around which local health systems should develop. Although general practices are not the only part of the NHS providing contact, coverage and continuity, no other part of the NHS offers these features for so many people, in a manner that consistently gains public approval and that has stood the test of time.

Consultations are the heart of general practice and cumulatively provide not only high levels of population coverage, but also continuity of contact with individuals, allowing the development of relationships and trust. They also provide serial starting points for anticipatory care, after current problems have been addressed.

However, while consultations are essential, they are no longer sufficient. GPs cannot do everything and have no wish to do so. Consultations provide opportunities to instigate referral to other professionals and services, either inside the practice, within the local community or further afield.

Pursuing the wheel analogy, hubs need connections to rims, spokes and axles. GPs must become wheelwrights.

The inner wheel of general practice links practitioner consultations with the activities of other members of the team. When several team members accumulate important information about patients and their problems, the 'spokes' of the wheel are regular channels of communication within the team. The outer wheel of general practice links practitioner consultations with many other NHS and local authority services within the local community. Some practices also link to non-medical community resources for the help they can provide for patients ('Social Prescribing', see Annex F).¹⁷

In deprived areas, the spokes connecting hubs and other local services have to be short. A consistent finding from many meetings of Deep End practitioners is that, if referral is not timely, local and to a familiar person or setting, patients are less likely to attend. Therefore, attached workers are in demand, for example working in mental health, alcohol and addictions or child surveillance.

Attached workers are not a panacea, and, as with all aspects of joint working, their usefulness depends on productive professional relationships, based on personal contact, positive experiences, regular communication, reciprocity and trust. Deep End practitioners report good and bad examples of attached workers in practice.

The challenge is not only how general practice hubs relate to the rest of the local health system, but also how area-based services relate to all of the practices within their area. For example, in the Deep End meeting on alcohol problems in adults under 40, GPs were impressed by the range and quality of services provided by area-based Community Addiction Teams. However, by their own admission, such teams deal with only about 40% of people with severe alcohol problems in their areas.¹⁴ Health systems audit needs to take account of 100% of the population needing care.

Every local system depends on the sum of the relationships of which it is comprised, including relationships between practices and other professionals and services. Currently, there is little mapping or review of these relation-

ships, although their quality is often well known to everyone at ground level and frequently determines how services are provided and used. Gang culture is not only a feature of deprived housing estates. It also features widely in public services.

When such relationships are reviewed, a hierarchy emerges, ranging from no knowledge, to knowledge but no contact, to cooperation on a scale from high to low volume and a spectrum from good to bad results. Genuine collaboration occurs when joint working is valued at every level, and planned and reviewed on a regular basis. Neither general practices nor area-based services can do this on their own. It takes two to tango.

An intrinsic feature of general practice, in contrast with specific care programmes, is that hub, spoke and rim relationships are needed for many different groups of patients, including those with CVD risks, multiple morbidity and problems of old age, as well as vulnerable families. With a full complement of wheels, connected, balanced and serviced, general practice need not be stuck in the present. It could transport health care into the future.

14 | A social institution based on mutuality and trust

Mutuality and trust are enshrined in policies, guidelines and practice concerning relationships with patients, but these are not the only relationships in the NHS requiring mutuality and trust.

In 1948 when the NHS was born, the challenge of universal coverage was to include everyone, regardless of ability to pay. This remains an important objective, but it is no longer sufficient. Now that health care can improve public health, via the mass delivery of effective care, the test of universal coverage is that health systems should be seen at their best where they are needed most. Otherwise health care will widen rather than narrow inequalities in health. This cannot be achieved by pandering to the loudest voices, whether these come from the worried well, local interests or corporate health care.

After two years of activity, the Deep End Project has only reached the end of its beginning, but we hope that two important objectives have been achieved: that it will no longer be acceptable to address the 'social determinants of health' or inequalities in health without mentioning the inverse care law and that GPs will no longer be exhorted to address health inequalities without reference to the circumstances and constraints under which they work.

In capturing the experience and views of GPs at the Deep End, this series has highlighted not only the substantial social capital that exists in general practices serving very deprived areas, in terms of knowledge, commitment, contact, coverage and relationships, but also the frustration of not being able to use these resources to full effect.

General practice in the Deep End should be centre stage in NHS efforts to reduce the health effects of socioeconomic disadvantage, not only as part of the new and important focus on early years (which won't impact on inequality statistics for decades) but also in addressing the health problems and shortened life expectancy of adults.

The 100 most deprived general practices in Scotland are where the NHS needs to show it can make a difference. The cost of not doing so can be counted in human lives, which are shorter and harder than they need to be.

This series has made frequent reference to the work of Julian Tudor Hart, not as a model to be slavishly followed, but as an illustration of core principles and active ingredients. First and foremost was his acceptance of responsibility

for the health of all his patients, using epidemiology to measure not only what he had done but also what he hadn't done, and showing concern for patients who had fallen out of the system. We have tried to correct the misunderstanding that he lowered premature mortality by screening, health checks and an exclusive focus on cardiovascular risk. Instead, he used case-finding and routine consultations for most of what he did, and, while evidence-based medicine was important and used whenever it was available, his main intervention was unconditional, personalised, continuity of care, 'initially face to face, eventually side by side', for whatever problem or combination of problems his patients presented. The QOF has devalued this important aspect of care.

The Tudor Hart example illustrates that the NHS is neither a commercial business to make profits, nor a public utility providing services for choosy consumers, but a social institution based on mutuality and trust. This type of care is not needed by everyone, but it is certainly needed by the substantial numbers of patients with multiple morbidity who account for the majority of encounters in general practice.

Mutuality and trust mean relationships based on personal recognition, joint work, effective communication, understanding and respect of each other's roles, positive experiences and confidence in the future. All this is enshrined in policies, guidelines and practice concerning relationships with patients, but these are not the only relationships in the NHS requiring mutuality and trust.

The same features need to characterise relationships between general practices working together as a whole system (as begun by the Deep End Project), between general practices and other local professions and services (tackling the ubiquitous problem of healthcare fragmentation), and between GPs and others concerned with the health of local communities (bridging the gulf between list-based and area-based approaches). On each trajectory, there is a dearth of information, infrastructure and will, with too much resource locked up in central institutions.

If the NHS is to be seen at its best where it is needed most, Deep End practices need help, not only to address the inverse care law with additional time and attached workers, but also to play a full part in the continuing development of the NHS, building mutuality and trust. As the Deep End Project enters its next phase, we seek opportunities and partners to show what general practice can do.

15 | Reflections on the Deep End

**It is better to travel hopefully than to arrive,
and the true success is to labour.**

Robert Louis Stevenson

After two years, 15 meetings and 12 articles in the BJGP, it is timely to reflect on the early progress and immediate future of the Deep End Project.

The Project has given group identity to the 100 general practices that serve the most severely deprived populations in Scotland. Scattered across 11 local NHS organisations, Deep End practices are a majority of practices in only two of these areas. Not only do most practices now know their rank in the top 100, but the Deep End has also been mentioned by keynote speakers at national and international conferences, and cited in the *Lancet*^{21,22} and *British Medical Journal*.²³ Correspondence from practices in England, Belgium, Ireland and the United States has given the Project an international dimension.

The first meeting in 2009, bringing together two-thirds of Deep End practices, was cathartic. Assembled for the first time in the 60-year history of the NHS, there was an instant bond. It may have helped that apart from three guests there were only GPs present. The group was immediately energised and positive.

Fourteen smaller meetings, costing about £70,000 and involving 73 practices in total, were subsequently organised and reported, all within 14 months, reflecting the speed with which GPs can do things when they wish (Annex A). Twelve Deep End GPs comprised the steering group. An informal alliance of colleagues from the University of Glasgow, RCGP Scotland and the International Futures Forum provided support in kind.

Capturing experience as evidence

The evidence that meetings sought to capture was the experience and views of practitioners working in the most deprived areas. These were rich discussions. It seemed that only a small number of GPs were sufficient to describe

experiences that are common to many. Observers, such as policy advisers from the Scottish Government Health Department (SGHD), were also enthused. Some were used to seeing GPs only across negotiating tables and had never witnessed GPs sharing and discussing the work they do. A note was taken of everything that was said, summary reports were written and the contents and conclusions were checked with participants.

A key factor was the budget, which allowed locum payments to be made and a wide range of practices to be represented. The Scottish Government funded three meetings, but most of the locum budget was obtained by serendipity. The Glasgow Centre for Population Health had funded the Primary Care Observatory Project,²⁴ describing the epidemiology of primary care based on general practice denominators, but the project had ended early after a key staff departure. Having described Deep End general practices in detail, the logical next step was to use the unspent funds to contact the practices directly. Fortunately, the funder agreed.

The jargon of public health, NHS management and government health policy was notably absent. The issues were familiar but the language was different. Some flagship government health policies were barely recognised by Deep End GPs. Not only can the NHS be a Tower of Babel; its highest and bottom-most reaches also can be worlds away.

The Deep End discussions had authority, however, with groups reflecting dozens and occasionally hundreds of years of collective experience of working in the front line, seeing patients, communities and society as they are. A huge amount of knowledge had been acquired by practitioners and their colleagues. There was frustration at not being able to apply such knowledge, especially in relation to at-risk families, and anger when such knowledge had been casually thrown away via redeployment or loss through burnout of attached nursing staff.

Health care as a social determinant of health

Meetings took for granted, indeed affirmed, the value of general practice, improving population health not only via the mass delivery of evidence-based medicine but also via the unconditional, personal continuity of care provided for all patients, whatever condition or combination of conditions they present. The contribution of general practice to improving health and narrowing inequalities in health is not so much via the learning of new tricks and delivery of externally devised toolkits as by increasing the volume and quality of what Deep End practices do.

Work in the Deep End is dominated by the number, severity and complexity of health and social problems within families and the difficulty of addressing such problems in short consultations.²⁵ In a survey of GP trainees in Deep End practices, one of their concerns was exposure to 'the worried well'. They had heard and read about such patients, but had not come across them in the Deep End.

Everyone understands that the social determinants of poor health are deeply rooted and difficult to address, but health care is also a social determinant of health and could do much more. Deep End practitioners would like health policies that value and support long-term commitment.

Addressing the inverse care law

Having raised the profile of the Deep End, what next? Will it be a flash in the pan, adding to the innumerable (and thus, by definition, largely ineffective) reports, plans and policies addressing inequalities in health?

There is a huge opportunity. Deep End practices achieve as many points in the QOF as other practices; 45 practices teach undergraduates; 46 take part in research; 67 took part in the activities of the Scottish Primary Care Collaborative; 61% of the 335 Deep End GPs have the MRCGP or FRCGP. The inverse care law in Scotland is not explained by good practices in affluent areas and bad practices in deprived areas; rather it is the difference between what Deep End practices can do and could do if supported to address unmet need.

Addressing the inverse care law is not rocket science. The problems are time and links. NHS Scotland is well placed to show the world what universal coverage and needs-based services can achieve. Of course, targeting only the most deprived areas is insufficient. What is needed in the Deep End is also needed in less deprived areas, serving pocket

rather than blanket deprivation, on a pro rata basis according to the principle of proportionate universalism.²⁶

GPs at the Deep End cannot solve the inverse care law on their own. Three other essential ingredients are: first, political commitment (and lack of professional opposition) to the NHS being at its best where it is needed most; second, national support for the scattered front line; and, third, realignment of local NHS resources, services and structures to support general practice hubs.

Wheels are beginning to turn. A randomised, controlled trial of extra time for consultations for patients with multiple morbidity is underway. The Links Project (Annex F) has explored Deep End practices' knowledge and use of non-medical community resources. It has led to the Bridge Project, promoting wellbeing and delaying disability in elderly patients in Deep End practices. Proposals are being drawn up to develop joint working with colleagues in mental health, alcohol and addiction workers, and vulnerable families. A second national meeting is planned for May 2012, with government funding.

GPs at the Deep End are on a new trajectory. We do not know where it will end, but it is good to be marching together on the right road.

References

- 1 RCGP Scotland Health Inequalities Short Life Working Group. *Time to Care: health inequalities, deprivation and general practice in Scotland* Edinburgh: RCGP Scotland, 2010.
- 2 The Scottish Government. *Scottish Index of Multiple Deprivation: 2009 general report*, 2009, www.scotland.gov.uk/Publications/2009/10/28104046/1.
- 3 Bunker JP. The role of medical care in contributing to health improvements within societies *International Journal of Epidemiology* 2001; **30**: 1260–3.
- 4 Mackay DF, Watt GCM. General practice size determines participation in optional activities: cross-sectional analysis of a national primary care system *Primary Health Care Research and Development* 2010; **11**: 271–9.
- 5 Gillies JCM, Mercer SW, Lyon A, et al. Distilling the essence of general practice: a learning journey in progress *British Journal of General Practice* 2009; **59**: 356–63.
- 6 Mercer SW, Fitzpatrick B, Gourlay G. More time for consultations in a high deprivation practice is associated with increased patient enablement *British Journal of General Practice* 2007; **57**: 960–6.
- 7 The Scottish Government. *Health Inequalities in Scotland*, www.scotland.gov.uk/Topics/Health/health/Inequalities.
- 8 Mercer SW, Watt GCM. The inverse care law: clinical primary care encounters in deprived and affluent areas of Scotland *Annals of Family Medicine* 2007; **5**: 503–10.
- 9 McKinsty B. Do patients wish to be involved in decision making in the consultation? A cross-sectional survey with video vignettes *British Medical Journal* 2000; **321**: 867–71.
- 10 Watt G, O'Donnell C, Sridharan S. Building on Julian Tudor Hart's example of anticipatory care *Primary Health Care Research and Development* 2011; **12**: 3–10.
- 11 Deep End Report 4 and Deep End response to Keep Well Consultation, www.gla.ac.uk/departments/generalpracticeprimarycare/deepend.
- 12 Tudor Hart J, Thomas C, Gibbons B, et al. Twenty five years of case-finding and audit in a socially-deprived community *British Medical Journal* 1991; **302**: 1509–13.
- 13 Deep End Report 12. *Working Together with Vulnerable Children and Families*, www.gla.ac.uk/departments/generalpracticeprimarycare/deepend.
- 14 Deep End Report 11. *Alcohol Problems in Adults under 40*, www.gla.ac.uk/departments/generalpracticeprimarycare/deepend.
- 15 Sigerist HE. *Medicine and Human Welfare* New Haven: Yale University Press, 1941.
- 16 Mercer SW, Cawston PG, Bikker AP. Quality in general practice consultations: a qualitative study of the views of patients living in an area of high socio-economic deprivation in Scotland *BMC Family Practice* 2007; **8**: 22.
- 17 Deep End Report 9. *Social Prescribing in Very Deprived Areas*, www.gla.ac.uk/departments/generalpracticeprimarycare/deepend.
- 18 The Scottish Government. *Long-Term Monitoring of Health Inequalities* Edinburgh: Scottish Government, 2010.
- 19 Tudor Hart J. Relation of primary care to undergraduate education *Lancet* 1973; **ii**: 778–80.
- 20 Tudor Hart J. *A New Kind of Doctor* London: Merlin Press, 1988, p. 187.
- 21 Horton R. Offline: face to face, side by side *Lancet* 2011; **377**: 1224.
- 22 Horton R. 8 minutes *Lancet* 2011; **378**: 1538.
- 23 MacAuley D. Floundering in the deep end: reflections on the RCGP conference, <http://blogs.bmj.com/bmj/2011/10/27/domhnall-macauley-floundering-in-the-deep-end>.
- 24 Watt G. *Connecting with General Practice to Improve Public Health: report of the Primary Care Observatory and Deep End Projects* Glasgow: Glasgow Centre for Population Health, 2011, www.gcph.co.uk/publications/277_gps_at_the_deep_end.
- 25 Watt G. The inverse care law today *Lancet* 2002; **360**: 252–4.
- 26 Commission on Social Determinants of Health. *CSDH Final Report: closing the gap in a generation: health equity through action on the social determinants of health* Geneva: World Health Organization, 2008.

Annex A | Deep End meetings and reports

Fifteen meetings were held between September 2009 and February 2011:

- 1 First meeting at Erskine
- 2 Needs, demands and resources
- 3 Vulnerable families
- 4 Keep Well and ASSIGN
- 5 Single-handed practice
- 6 Patient encounters
- 7 GP training
- 8 Social Prescribing
- 9 Learning journey
- 10 Care of the elderly
- 11 Alcohol problems in adults under 40
- 12 Caring for vulnerable children and families
- 13 The Access Toolkit: views of Deep End GPs
- 14 Reviewing progress in 2010 and plans for 2011
- 15 Palliative care in the Deep End.

Reports and summaries can be seen at:
www.gla.ac.uk/departments/generalpracticeprimarycare/deepend.

The collated summaries are also available in the *Connecting with General Practice to Improve Public Health* report of the Primary Care Observatory and Deep End Projects, Glasgow Centre for Population Health, 2011, which can be downloaded at:
www.gcph.co.uk/publications/277_gps_at_the_deep_end.

Annex B | Publications, presentations and profile

Twelve articles were published in the *British Journal of General Practice* in 2011:

- ▶ GPs at the Deep End, *BJGP* 2011; **61**: 66–7
- ▶ Patient encounters in very deprived areas, *BJGP* 2011; **61**: 146
- ▶ Anticipatory care in very deprived areas, *BJGP* 2011; **61**: 228
- ▶ Working with vulnerable families in deprived areas, *BJGP*; **61**: 298
- ▶ Social Prescribing in very deprived areas, *BJGP* 2011; **61**: 350
- ▶ Alcohol problems in very deprived areas, *BJGP* 2011; **61**: 407
- ▶ The Keppoch Medical Practice, *BJGP* 2011; **61**: 463
- ▶ Learning journeys: where to, who with and how? *BJGP* 2011; **61**: 519
- ▶ Time to make a difference, *BJGP* 2011; **61**: 569
- ▶ The tortoise and the hare, *BJGP* 2011; **61**: 629
- ▶ Inventing the wheel in general practice, *BJGP* 2011; **61**: 685
- ▶ A social institution based on mutuality and trust, *BJGP* 2011; **61**: 741.

An editorial appeared in 2012:

- ▶ Reflections at the Deep End. Editorial, *BJGP* 2012; **62**: 6–7.

Annex C | Deep End practices

The original 100 practices, classified according to the 2006 version of the Scottish Index of Multiple Deprivation (SIMD), were based in ten community health (and social care) partnerships. The 2009 version of SIMD resulted in 14 new practices joining the top 100. Six of the original practices had either merged or dissolved. It was decided to continue to include the eight ‘displaced’ practices in the Deep End group (shown in brackets below), while retaining all of the original 100 practices.

NHS area	All general practices	Number of Deep End general practices	
		SIMD 2006	SIMD 2009
Glasgow East	35	28	27 (2)
Glasgow North	19	18	18
Glasgow West	45	16	15 (2)
Glasgow South-West	27	14	12
Glasgow South-East	29	9	4 (3)
Inverclyde	16	5	7
Renfrewshire	30	1	1
Edinburgh	71	5	5 (1)
Dundee	27	2	4
Ayrshire	57	2	3
Lanarkshire	98		3
Grampian	82		1
Total		100	100 (8)

Figures in brackets refer to practices no longer in the ‘top 100’ based on SIMD 2009, but which have been kept in the project.

Seventy-six Deep End practices are in Glasgow City and 84 in Greater Glasgow and Clyde (GGC). Notwithstanding the 16 other Deep End practices based outside GGC, scattered across five health boards, it is clear that the problem of meeting healthcare needs in areas of blanket deprivation is mainly a GGC rather than a Scottish problem.

Annex D | Deep End advocacy

GPs at the Deep End have twice contributed to public advocacy, writing multi-signatory letters to the *Herald* newspaper in response to the parliamentary debate on minimal alcohol pricing, and also in the run-up to the 2011 Scottish parliamentary elections. See the Deep End Manifesto 2011 at www.gla.ac.uk/departments/generalpracticeprimarycare/deepend.

13 SEPTEMBER 2010

The Editor | The Herald | Glasgow

ALCOHOL IN GENERAL PRACTICE

Dear Sir

We write as general practitioners working in the most deprived areas of Scotland, with special experience of the problems of alcohol. Our interest is not through choice, but because of the huge, recent and increasing importance of excessive alcohol consumption as a cause of premature death, physical illness and social harm affecting our young patients.

Research studies show the social patterning of alcohol problems, not only the higher levels of consumption in poor areas, but also the higher levels of harm for a given level of consumption. Death rates from alcohol liver disease are five times more common in poor areas compared with the most affluent areas.

Scotland's statistics are shocking, but 'statistics are people with the tears wiped off'. The current debate about alcohol pricing can lose sight of the misery and devastation that affects our patients

and their families, especially the lasting effects on children. Drunken disorder is only the most obvious problem. Every one of us knows of tragic cases of young adults whose lives, and whose family lives, have been ruined by alcohol. Women are particularly vulnerable. No one should die young and yellow from chronic alcohol poisoning.

This is not an issue that can be left to personal responsibility or the massed efforts of health practitioners trying hard to stem the tide. Any measure, such as minimal alcohol pricing, which makes it more difficult for people to consume regular excessive amounts of alcohol should be seized, as a public health measure of the highest importance. Cross party support is the least we should expect from our politicians, especially those representing the most deprived constituencies, in confronting this very real and lethal epidemic.

Signed by the following NHS general practitioners:

Jim O'Neil · *Lightburn Medical Centre*
 Margaret Craig · *Allander Street Surgery*
 Stephen Macpherson, Elizabeth Day, Robert Jamieson · *Bridgeton Health Centre*
 Peter Wiggins · *Castlemilk Health Centre*
 Catriona Morton, Michael Norbury · *Craigmillar Health Centre*
 Harjinder Bachu, Ian Aitken · *Crail Medical Practice*
 Peter Cawston, John Nugent · *Drumchapel Health Centre*
 John Goldie, Dhami Davinder, Emma Shepherd · *Easterhouse Health Centre*
 Sally Al-Agilly · *Edinburgh Road Surgery*
 Alison Macbeth, William Lam, Scott Wilson · *Gilbertfield Medical Centre*
 Andrea Williamson, Ruth Spencer · *Glasgow Homeless Health Service*

Catherine Mills · *Gorbals Health Centre*
 Euan Paterson, Stephanie Maguire, Anne Mullin · *Govan Health Centre*
 Clare McCorkindale · *Kelso St Surgery*
 Ronnie Burns · *Parkhead Health Centre*
 Maria Duffy, Douglas McKnight, Nick Treadgold · *Pollok Health Centre*
 Lindsey Pope · *Port Glasgow Health Centre*
 Robert Mandeville, Louis Alguero, Petra Sambale, Douglas Rigg, Susan Langridge · *Possilpark Health Centre*
 Gerry Spence · *Shettleston Health Centre*
 Helga Rhein · *Sighthill Health Centre*
 Georgina Brown, John Candy · *Springburn Health Centre*
 Roger Black · *Whitevale Medical Group*
 Professor Graham Watt · *University of Glasgow*

25 APRIL 2011

To the editors of national newspapers in Scotland

THE NHS SHOULD BE AT ITS BEST WHERE IT IS NEEDED MOST

Dear Sir

Scotland has an admirable record of providing comprehensive health care which is free at the point of use, and has been steadfast in protecting its NHS from the ravages of market competition, which continue to threaten the NHS in England.

However, as the continuing statistics on health inequality show, NHS Scotland has still to address the inverse care law, whereby the availability of good medical care tends to vary inversely with the need for it in the population served.

While NHS resource distribution formulae and general practitioner contracts have recognised for a long time the increased health problems, multiple morbidity and needs for care of elderly populations, they have been much less effective in providing resources to meet the increased health problems, multiple morbidity and social complexity of younger patients living in very deprived areas.

As general practitioners working in the 100 most deprived general practices in Scotland, we are the front line of the NHS in Scotland as it battles with health inequality. We are in daily contact with large numbers of patients, with unrivalled levels of continuity and coverage, and have substantial experience and knowledge of the health problems of people living in Scotland's poorest communities, including vulnerable children, and those struggling with

mental health and addiction problems in addition to physical ailments.

The inverse care law in Scotland is not a matter of good medical care in affluent areas and bad medical care in deprived areas. It is the difference between what general practice and primary care can currently achieve, in meeting the needs of patients in very deprived areas, and what could be achieved, if the service were better resourced to address levels of need.

The major issue which must be addressed, and whose solution requires political action, is the shortage of time within consultations to address patients' needs in very deprived areas. Although other measures are needed, without this essential building block, the NHS will continue to fail in its attempts to narrow health inequalities. Longer consultations are needed to work with patients on their problems, to take a preventive approach and to instigate links to other services.

The NHS has many challenges to face, but should be at its best where it is needed most. We call on political parties contesting the forthcoming election to commit themselves to eliminating the inverse care law in Scotland. Their first step should be to provide general practices in the front line with additional time for patient consultations.

Members of the Deep End Steering Group:

Georgina Brown, GP • *Springburn Health Centre*
 John Budd, GP • *Edinburgh Homeless Practice*
 Peter Cawston, GP • *Drumchapel Health Centre*
 Margaret Craig, GP • *Possil and Springburn*
 Susan Langridge, GP • *Possilpark Health Centre*
 Stewart Mercer • *Professor of Primary Care Research, University of Glasgow*
 Catriona Morton, GP • *Craigmillar Health Centre*

Anne Mullin, GP • *Govan Health Centre*
 Jim O'Neil, GP • *Lightburn Medical Centre*
 Euan Paterson, GP • *Govan Health Centre*
 Petra Sambale, GP • *Keppoch Medical Centre*
 Graham Watt, Professor of General Practice • *University of Glasgow*
 Andrea Williamson, GP • *Glasgow Homeless Health Services*

Annex E | Listening and learning from the experience of those on the NHS's front line

The following appeared as a feature article in the *Holyrood* magazine, 19 September 2011.

THE THREE GPs assembled before me have more than 60 years' experience between them of working in general practice. As members of the Deep End Project – a group of GPs assembled from the 100 most deprived general practices in Scotland – the GPs from the Govan Health Centre see themselves and their colleagues as the NHS' frontline in the ongoing battle against Scotland's endemic health inequalities.

Life expectancy for people living in the most deprived areas of Scotland is around 20 years lower for men and 18 years lower for women, compared with those living in the most affluent areas. Further, according to a recent report by RCGP Scotland, deprived adults are nearly four times more likely to die from coronary heart disease between the ages of 45–74, and more than 12 times more likely to die of an alcohol-related condition.

GPs face the stark realities of these inequalities on a daily basis. However, despite their unique vantage point, the Deep End Project, established two years ago, is the first time in the NHS' 60-plus year history that these practices have been convened and consulted in an attempt to capture their previously unheard views and experience.

The GPs from Govan clearly relish the opportunity to speak up for their patients. 'We work in an area with lots of people who have got huge problems with deprivation, which has a massive impact on their health and not enough people care enough about that and it is not fair. That sounds a bit idealistic but that is generally what it is about: a good bunch of people who have got a raw deal and something needs to be done,' says GP Euan Paterson.

His colleague, GP Anne Mullin, also got involved because she believes patients' everyday struggles need to be shared more widely. 'That's why I got involved in the Deep End because I thought this micro-political level of the everyday stories we hear – people say that is just an anecdote, it isn't really evidence, but that's nonsense. This is evidence. What these people tell us is evidence of whether the system is working or not. Whether society is functioning or not functioning.

'But we don't yet have a sophisticated way of doing that because it is part of the patients' narrative and so it is not really regarded in the same way as, say, a blood pressure measurement in terms of evidence.' Woven together, however, patients' narratives create a more complete picture of what life is like for those who bear the brunt of inequality.

Completing the trio, Dr Carolyn Gillies reflects on her experiences with one young patient who, she says, typifies the multiple challenges her patients face. 'This is a young guy, he's now 22. He was brought up in poverty with a big family, none of whom have ever worked but despite this – and despite being assaulted when he was 16 and nearly killed, after someone came up and hit him around the head with a metal bar, fracturing his skull, which he got over and got a plumber's apprenticeship. But he has been to see me a few times recently because he is not coping emotionally. Because he can't get a job.

'He can't get a job with a firm because it depends on who you know. He can't get a job on his own because he can't afford driving lessons, let alone get his own vehicle. He currently has a girlfriend who he would quite like to get married to and settle down and have kids with but they

are living with his mum. He is really quite an old-fashioned boy and he doesn't want to do that until he has got enough money saved. And he is one of these people who comes through all of this still intact, but not working and living on benefits and now seeing me because he just needs to chat about it sometimes.'

None of the GPs is under any illusion about the numerous social determinants of poor health; nor that many of the solutions lie beyond their remit and outwith general practice. Sometimes, Paterson says, all he can offer is to 'simply sit and witness their suffering', and let them know that they have been heard. 'Not with any intent to do anything about it,' he says, 'but just to sit there and give validity to their story so they hopefully go away thinking it is at least entirely appropriate for me to feel the way I feel. I'm not going mad. I'm not a bad person. I'm not part of the sick society that we hear about from our esteemed leaders down south. It is just rotten and at least someone has said to me, "Yeah, it is rotten and I'm sorry that it is."'

Collectively, this turns GPs into a valuable source of information with the knowledge to flag up emerging challenges much earlier than they are currently being identified, Mullin argues. 'Look at heroin in Glasgow. It was established probably in Possil before anywhere else in Glasgow. It was there for about ten years before, politically, it became a huge issue, but by then you've had a decade of it mushrooming out of control.'

The same is true today of the impact the welfare reforms are having in these communities, she adds: 'I might see ten people coming in saying they are destitute this week. If we are all seeing that then that is a huge problem. That is not just ten isolated cases. It is an issue that, politically, has to be dealt with.'

GPs are a treasured resource in these communities, and yet general practice itself is under-resourced to deliver all that the NHS could be achieving in terms of improving health and narrowing health inequalities, they argue.

Indeed, it is incongruous that the availability of good medical care tends to vary inversely with the need for it in the population served, argues Graham Watt, a Professor of General Practice at the University of Glasgow who also sits on the project's steering group. If this inverse care law is not addressed, then the health inequalities

resulting from it will persist, he explains. 'Since 1948, the NHS has supplied GPs in the same way that bread, butter and eggs were rationed in World War 2 – everybody gets the same', Watt wrote in an article published in the *British Journal of General Practice* earlier this year.

'In severely deprived areas, this results in a major mismatch of need and resources, with insufficient time to get to the bottom of patients' problems – hence the swimming-pool analogy in which GPs at the Deep End are treading water.' The NHS should be seen at its best where it is needed most, he argues, adding that the goal for healthcare must be to find ways of increasing the volume, quality and consistency of care in deprived areas.

When asked in what way circumstances could be changed to allow them to achieve more, the GPs from Govan have an answer ready. 'I need more time with each individual patient. That's it. That is the only thing I'm after', states Paterson concisely.

Patients in deprived areas often have multiple overlapping health and social problems, that a ten-minute consultation can prove insufficient to unpick, they explain.

'All that we do in general practice is narrative-based', explains Mullin. 'We sift out the hard facts of their medical issues from the narratives that patients give you. We're not vets. We don't sit and stare at patients and try and work out what is wrong with them. They come in and tell us things and they muddle it up, though, with the story of their lives. "My housing is awful and by the way, I've had this chest pain for two days", and we've got to decide whether that is cardiac or not. That is what we do. That is what your skill as a GP is but it takes time.'

They do not mean to imply that GPs working in other areas are not also busy – they know that they are – or that they do not have demanding patients; the difference is that these complex cases make up the bulk of Deep End GPs' workload and so are the norm, not the exception. All of the Deep End practices – which were identified by ranking the practices according to the proportion of registered patients living in the most deprived 15 per cent of Scottish postcode data-zones – have at least 50 per cent of their patients in this category, rising to over 90 per cent in the most deprived practice population.

Eighty-five of the Deep End practices can be found in Glasgow City; and across the river from Govan, the Keppoch Medical Practice in Possilpark has the unenviable honour of topping the list of Scotland's most deprived practices.

Petra Sambale, GP, Keppoch Medical Centre says the main difference between the practice here and more affluent parts of the city is that 'very few easy cases' come through the door.

In 2003, the practice took part in a pilot study, led by Stewart Mercer, a Professor of Primary Care Research at Glasgow University, which provided increased time for consulting with complex cases. The pilot found that extra time was associated not only with increased reported enablement by patients with complex problems, but also reduced practitioner stress and increased reported enablement by other patients receiving usual consultations. Work is currently under way to evaluate this approach in a larger number of practices, with findings due in August 2012. However, Sambale is already persuaded and argues that the 'promising' initiative deserves wider and longer-term application. She also found participating in the research was a useful learning exercise all round.

'That was certainly how it started for all of us to become much more aware of the deprivation issues and the pressures we were under', she says. 'Getting feedback from the university that we were at that time the most deprived practice in Scotland, finally, a lot fell into place for us and made it clear to us why we were so stressed.'

The additional pressures working in an area of concentrated deprivation brings should not be underestimated. 'The intensity of working in a practice in a deprived community is significant', explains Dr Alan McDevitt, deputy chairman of the BMA's Scottish General Practitioners' Committee. 'Patients often have multiple chronic diseases and significant health and other needs. Practices in these communities don't just need more money to provide services; they need support to be able to offer patients the care they need when they come to the practice.'

However, funding cuts are threatening the continuity of care and impeding the quality of service practices are able to provide, Sambale says. 'In the last five years we had periods without any health visitor in the practice. We then had a succession of three different health visitors. One, who

left, was excellent. She was the best health visitor I've ever worked with but she left because she said she had never come across that level of deprivation and need and that lack of support like here. She became ill and had to protect herself and had to leave and there was nothing we could do.'

Gaining the patients' confidence for yet another new face can take time, however, and GPs increasingly find themselves having to fill the gap, Sambale explains. 'Our patients said to me, "Who is here now? I'm not going to see that person. I'm fed up meeting new faces." So what is happening, again if you look at our time and resources as a GP, you suddenly have to provide health-visitor cover. You have to provide services you shouldn't be providing because you are the only person who is there to deliver continuity of care.'

In such cases, burnout is a real concern, she states, adding that if you have 'the two big "Cs" in your work ethic – care and compassion', this cannot be sustained indefinitely.

Not everyone is suited to work under such conditions, explains practice manager, Fiona McKinlay. 'They are not going to have the same career ... the same income if they went anywhere else ... the same work/life balance. I think it is almost the old-style doctor who chooses to come here. Watching the trainees who are coming through now there are fewer and fewer of those young GPs with that kind of mindset that the old-style family doctor had so I think it will be harder and harder to recruit doctors to come and work in areas like this.'

The practice's recent experience of recruiting a new partner only served to confirm McKinlay's fears. 'We advertised for a new partner and we had about 25 applications, many of them were clearly unsuitable. Once we had it narrowed down, we interviewed three people, actually, one didn't turn up because she got mugged on the way here. She got lost and stopped to get her phone out of the boot and got her handbag stolen. So she obviously decided she didn't want to work here after all. So in the end, we ended up interviewing two people.'

'Now, I know from colleagues that if they advertise for a partner in other areas you are overwhelmed and it is very, very easy to find another partner. But for us, there are so many aspects to the person that you are looking for that it is very complex.'

I ask Sambale what the attraction of working in such a deprived area is. 'What keeps me here is that I think it is one of the most challenging jobs you can have as a GP', she answers.

While this complexity is often overwhelming, she says it is also very stimulating to have had a unique opportunity to specialise in deprivation. 'I can say that because I have worked in one of the most expensive areas in Europe (in Germany) before this, so I have the direct contrast. But for me, the difference is this complexity. It is fun.'

Similarly, back in Govan, Gillies says she has learned a lot from working in an area of deprivation. 'I love working in Govan. I've been here about 25 years. I come from a nice middle-class background – my parents were teachers, nice upbringing and all the rest of it. But the amount that you learn about humanity and human nature is enormous.' Middle-class areas may see it as well, she continues. 'It has been so long since I've worked in one. But we see lots and lots of unhappiness due to circumstances and I think that is what we learn to deal with.'

For Mullin, working in Govan is simply a more natural fit. 'I identify with people living here. I come from a quite working-class background myself and the stories I hear are quite familiar stories, they are not alien to my ears. I think if I was brought up in social class one area and a quite aspirational family, perhaps I couldn't get on an equal field with them. But I actually don't see any difference between myself and my patients other than that I am now an educated person who has gone to university and got a profession.'

Putting aside these differences and meeting as equals is key to the success of the patient–doctor relationship, explains Paterson. 'I think that is something we can do in general practice that is massively important, which is to treat our patients as absolutely equal human beings at a human being level.'

He continues: 'They seem to accept that there is a professional gulf, that we know more, we've got more money, otherwise they wouldn't be coming to you. But it is a partnership that is based on the fact that I am a human and have been very lucky and you're a human and you're really unlucky. I think there is a huge role for general practice there because that then is about empowerment and that then is about worth. That is about self-

help and betterment and sustenance and reliance. And we can start that process.'

Beginning the much needed process of engagement and making these connections across the practices that work in such deprived areas has been an important achievement of the Deep End, argues Watt. The group has met 15 times to date and has reported thoroughly on the discussions that ensued, even producing a manifesto before the recent Scottish elections outlining key areas where improvements could and should be made. However, while the first meeting was jointly funded by RCGP Scotland and the Scottish Government, and subsequent meetings were supported by Glasgow for Population Health, this funding is coming to an end. Watt hopes the project can secure additional funding, however, he is concerned that their efforts will be dismissed as 'a talking shop' for GPs.

'Whenever I present the Deep End work to NHS colleagues, I make the point that none of them had to negotiate their attendance at the meeting with a colleague, who would fill in for them while they were absent', he says. 'But with that funding at an end, the initiative is in danger of being stalled.'

The process of meeting with other GPs working in similarly challenging circumstances and discovering how much convergence there is in terms of the problems they face has clearly been cathartic, professionally. They have valued the opportunity to come together and pool their experience in an attempt to improve services for their patients, and feel they have more to contribute to the debate.

'We inhabit a phenomenal position of trust in the community, which is a huge privilege, a bit worrying and very scary at times, but that is how it is', says Paterson. 'I think we have a massive political advocacy role in this with a capital "P". We are seeing this. We are living in it. We are working in it and you need to pay attention to this if you want a decent society for all.'

Katie Mackintosh

Health Correspondent
Holyrood magazine

Annex F | Summary of the Glasgow Links Project

The Links Project was a six-month project, sponsored by the Scottish Government's Self Management Programme, Long Term Conditions Unit and Long Term Conditions Collaborative (LTCC). The project was established in October 2010 to allow general practice teams to have the time and practical support to explore the nature of their connections with the communities they serve. Service improvement methodology was used to explore the potential for primary care to be a vital connector in communities to ensure that all sources of local support are identified and utilised.

The project provided was a chance to develop themes emerging from numerous recent reports and projects, and was designed to learn more about Social Prescribing and the reciprocal approaches required to encourage self-care and self-management of long-term conditions. (Social Prescribing is also known as community referral and signposting, and is a mechanism for linking patients with non-medical sources of support within the community.)

The project explored opportunities to connect local citizens, primary care teams, the voluntary sector and other providers of support, and how best to share and capitalise on local knowledge.

Recognising individual and local assets and taking advantage of all possible sources of support is particularly important in areas of high deprivation, where people are likely to be less empowered, have complex needs, poorer understanding, lower levels of literacy and are less willing to access support unless it is close by.

People's needs often span several service silos. Just as care needs coordination, so does local support. Local organisations provide information and services that some people find more accessible than statutory health services, and which may therefore be more likely to encourage positive change. However, local directories of support services may not be useful because information produced by libraries, CHPs, general practice, voluntary and community groups is often siloed, scattered, transient, not updated and hard to access.*

Most communities have a network of hubs that connect people and offer useful support, such as libraries, churches, schools, voluntary groups and community associations. However, many are not well known, may be unconnected and under used, poorly understood and may struggle to maintain their resources because of short-term funding cycles. During the course of the project, practice teams gathered data and case studies, and met to explore aspects of linking with communities that may influence signposting to non-medical resources.

Summary of results

- ▶ 3704 consultations in six practices were used to gather information.
- ▶ An average of 18% of patients seen were identified by practitioners as having a need for support.
- ▶ 50% of the identified need was for mental health or addiction services.
- ▶ Of those patients with an identified need, 75% were signposted to a resource.
- ▶ 57% of patients signposted expressed an intention to accept the opportunity.
- ▶ Of patients referred during January and February who were followed up by practices in February and March, 60% had contacted the community resource.
- ▶ 70% of those who made initial contact were still using the resource 4–6 weeks after signposting.
- ▶ Some patients were asked to rate the usefulness of the services on a scale of 1–5 (1 = not useful, 5 = very useful). Of the 35 who answered, 18 (51%) rated the service as useful (4 or 5) and 7 (20%) did not find it useful (1).

* Making local information easy to find is the aim of the ALISS (Access to Local Information to Support Self Management), a Scottish Government project. See www.aliss.org.

Between December and March:

- ▶ staff who knew enough about community resources to inform patients increased from 24% to 65%
- ▶ staff confidence to inform patients and recommend community resources increased from 43% to 81%
- ▶ staff who considered their practice had good links with community increased from 22% to 48%
- ▶ all practices identified previously unknown community resources, while some were building relationships with 'old and new' services, and all created or improved directories of community services.

Key observations about linking with community resources

- ▶ A significant number of people living in deprived areas were willing to accept a recommendation from a GP to attend a community resource.
- ▶ A significant number who accepted the recommendation were still attending 4–6 weeks later.
- ▶ Personalised, relationship-based approaches are important in connecting services.
- ▶ It is essential to form good relationships so that trust and common purpose is strengthened, to encourage sharing of care and to disperse responsibility.
- ▶ Online, up-to-date, local information to support community connections is essential.
- ▶ Links that are specific to local context appear to have value.
- ▶ Experiential learning and making connections are more powerful tools for understanding and generating action than reading pamphlets.
- ▶ Consultation time is a vital consideration in making effective use of the relationships that practices have with patients.
- ▶ Social Prescribing was an unfamiliar concept to some members of practice staff, but there were accounts of significant change in perspective.
- ▶ Practitioners were interested in using local resources if they had the opportunity to become familiar with them.

Key factors in meeting project objectives

- ▶ Local and national relationships and networks were key to successful organisation; the project was set up quickly with little bureaucracy.
- ▶ Securing a GP with strong leadership skills who engaged with local practices.
- ▶ Engagement of practice staff who were willing to invest their time and ideas (3704 consultations were utilised to gather data during a period of high demand).
- ▶ Scottish Government budget to allow staff time out of practice to use service improvement tools, make connections in community, and reflect on findings.
- ▶ Provision of project management and training in improvement tools.

Working with people you know is important. Cultivating local connections may present an important way to share responsibility for improving quality of health and wellbeing; however, a cultural shift may be needed to view partnerships within communities as a valuable asset. Adopting an organised approach to linking community resources may have significant mutual benefits for citizens, primary care teams and providers of support. An emerging vision for improving connections in communities is personalised and relationship based, supported by robust technology.

ISBN 978-0-85084-338-5



9 780850 843385

Published by the

Royal College of General Practitioners
1 Bow Churchyard, London EC4M 9DQ

Telephone 020 3188 7400 | **Fax** 020 3188 7401 | **Email** admin@rcgp.org.uk | **Web** www.rcgp.org.uk

Royal College of General Practitioners is a registered charity in England and Wales (No. 223106) and Scotland (No. SC040430).